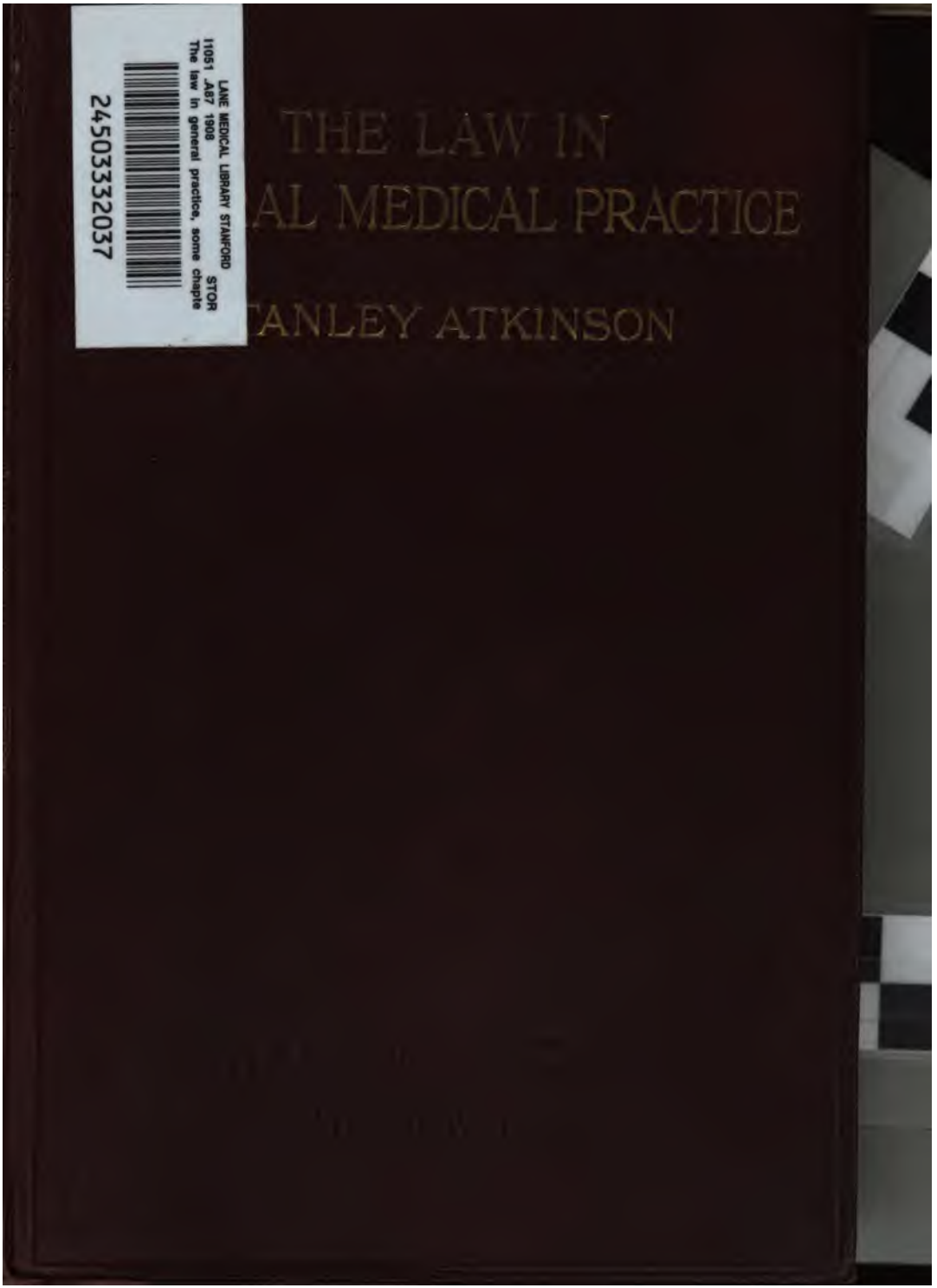

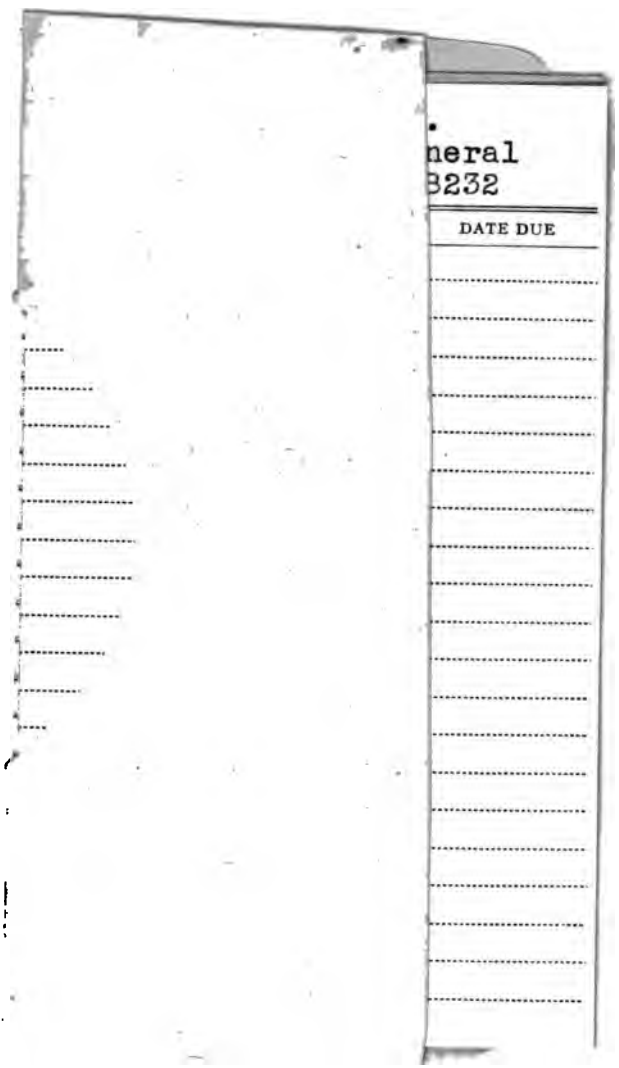

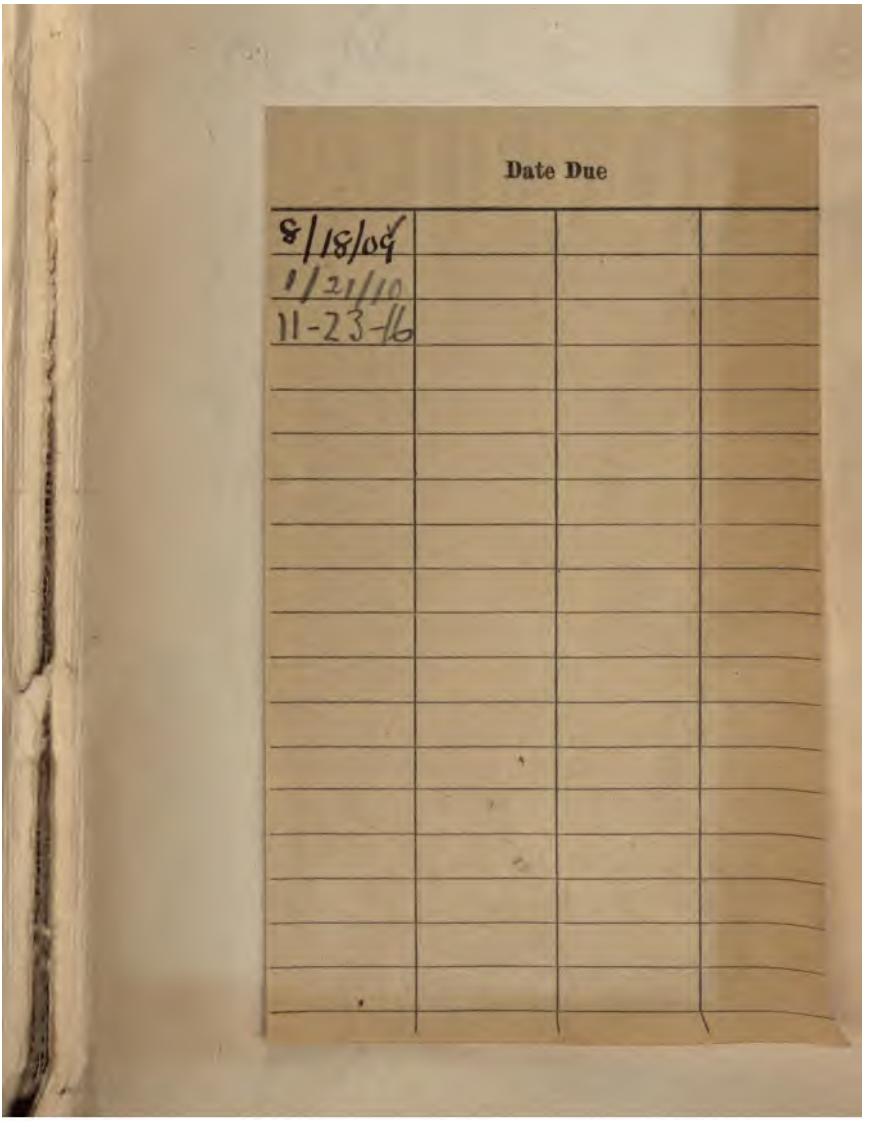

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THE LAW
IN GENERAL PRACTICE

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OXFORD MEDICAL PUBLICATIONS

THE LAW IN GENERAL PRACTICE

SOME CHAPTERS IN EVERY-DAY FORENSIC MEDICINE

BY

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PREFACE

It is sometimes said that medical students learn many things which they will never need in subsequent practice, and in subsequent practice will need many things which, as students, they never learned. The chapters in this book are intended to be a supplement to the ordinary instruction now given to students; they may also be useful to the busy practitioner.

I have to thank Mr. Digby Cotes-Preedy, M.A., of the Inner Temple and Oxford Circuit, Barrister-at-Law, for kindly reading the proofs.

STANLEY B. ATKINSON.

10, Adelphi Terrace, W.C.
May, 1908.

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CHAPTER I

PRACTICAL CAUTIONS AND PRECAUTIONS

Those who follow the calling of any one of the three great liberal professions—the Church, Medicine, or the Law—have found, from their bitter or better experience, certain abiding facts concerning human nature, experiences which might well be handed on as a professional legacy to a succeeding generation in particular and to the race in general. 'Human nature is the same in all the professions.' Historians proceed upon the assumption that the motives which influence us are identical with the motives which influenced our forbears. Unfortunately, the hardly-earned individual experience is usually allowed to perish with the observer, save in a few rare instances where a diary or a collection of aphorisms has been left for publication. The 'leading cases' of the medical practitioner are the best clinical reports which have been recorded.

The clergyman, the medical practitioner, and the lawyer are mainly concerned respectively with the mind, the body, and the estate of those to whom they minister: the first has been said to see men at their best, the last to see men at their worst, whilst the medical

adviser knows men as they are. It is wise for the medical practitioner never to act in the capacity of either of his fellow professionals. He may be suddenly called upon to advise in certain extra-professional emergencies, but more than advice-giving he should not attempt to do. He must respect the peculiar provinces of others as he would have others respect his. The three professions may be associated in solemn comradeship in the chamber of death, where what particularly concerns each separate adviser may have been unduly procrastinated until the moribund moments of life. Few will agree with the Antiquary's reply when Mrs. Hadoway observed:

'"Think what it would be if a man was to die without advice from the three learned faculties." "Greatly better than with them," grumbled the cynical Antiquary.'

Relations with Clergymen.

The realms of clinical theology or pastoral medicine it is not the scope of these pages to view, but, in passing, it may be urged that it is essential cordially to co-operate and to consult with ministers of religion, who may often be appropriately employed as the bearers to patients or to their friends of vital or of fatal news. Further, it will be a serious handicap to a medical practitioner's reputation and prospects of success if he ignores or fails to recognize the religious rites and ceremonies which are demanded on certain

momentous occasions by the belief of his patients or of the members of their families.

Medical Defence.

At the outset of his professional career a medical practitioner would do well to insure himself financially against the accidents and the diseases to which his special calling renders him liable. He should join at once and for ever a Medical Defence Society, remembering, nevertheless, that such an organization will not assist him in his legal disputes and difficulties with his medical neighbours, but only in his contests with laymen. The following words from the twentieth report of the Solicitor to the Medical Defence Union are of great importance in this connexion:—

'There are certain fundamental principles in connexion with medical defence which I desire once more to bring before the members of the Union, as embarrassments and misunderstandings are of not infrequent occurrence by reason of their being overlooked or imperfectly understood. The first of these is as to the duty which the member owes, not only to himself, but to the Union, in relation to any case in which he considers himself entitled to require their aid or support. It may be that his account is disputed on the ground of alleged neglect or incompetence, that he is threatened with action for malpraxis, or that he is involved in some question of dispute relative to an appointment which he holds. Be the cause, however, what it may, his first duty to himself and to the Union, if he requires their assistance, is to bring the matter immediately before them by communicating the details of it to the General Secretary.

'I could quote numbers of instances coming within my own personal observation in which for the want of exercising this simple precaution the member's position has been seriously prejudiced, and in certain instances irretrievably so. An explanation frequently offered is that the member regarded himself as competent to deal with the matter, and therefore allowed himself to be drawn into a correspondence containing admissions and explanations capable of being applied to his disadvantage. In other instances the excuse is that the member did not want to trouble the Union, and therefore let the matter rest or endeavoured to adjust it through his own personal solicitor, finding in the end that he had to come to the Union, and they, in turn, finding that his prospects of success had been materially prejudiced by his not coming earlier.

'Members must closely keep in mind the fact that medico-legal work is of a very special character, that the mere knowledge that a medical man has the support of the Union is in nineteen cases out of twenty sufficient to crush an action which is threatened, and, moreover, that, except under very special circumstances, the Union do not assume the control of any action in which the member has taken and acted upon legal advice otherwise than through themselves.'

Some General Precautions.

A good auditor of accounts and, if necessary, a respectable collector of unpaid debts should be employed. A stock of such books, blank certificates, and the requisite official forms should be always at hand. Experience has shown that a serious illness or a lawsuit are the events which the practitioner has to dread most from their effect upon the practice; if possible, both

should be kept as private as the circumstances will allow. A general rule should be made and well kept, never to become an executor of a will nor a trustee of an estate, even to oblige the most importunate patient; the fixed attitude should be *non possumus*. Every appearance or reputation of dabbling in the occult or the mysterious should be shunned; patients object to being 'thought-read'. If the practitioner allows an eccentricity to develop in one item the public is apt to test all his capabilities by that standard; further, it is unwise to be known as an expert in anything other than clinical matters, the former excellence is apt to discount proficiency in the latter. 'He is a bold man who trusts one that is making speeches and coaxing voters to meddle with the internal politics of his corporeal republic' (Oliver Wendell Holmes).

Annually published diaries and directories should be carefully perused and the current professional press should be followed. Every one is supposed to know the law and to be cognizant of any change which may be made and published through official channels. Courtesy alone allows those most concerned to be directly notified. Occasionally the pages of the *Medical Register* (published annually since 1858) should be scanned, to see that one's own name and the names of neighbours have not inadvertently been omitted. It was declared judicially in 1876: 'A person who is on the *Medical Register* may call himself what he likes.'

The medical practitioner should direct his executors to destroy forthwith and unread all his private letters and case-notes, other than such collection of clinical facts as he has observed and may wish to have placed upon record. Whenever possible he should give advice orally and avoid affording written opinions. This is the practice of the police. With regard to professional letters, especially those which are of the variety which are opened first and replied to last, it is a good plan to sleep upon the answer before it is posted; the publicity of a post-card must consistently be guarded against and objected to (see *The Lancet*, 1908, vol. i, p. 171).

The Family Practitioner.

Certain cardinal rules of conduct have been laid down by those of great experience as guides for those who wish to succeed in a general family practice. 1. Use the utmost influence in perpetuating family life; discourage ruptures and separation. To this end great discretion must be used as to what should be told and what withheld within the family. 2. Inspire hope wherever failure is not absolutely sure; never say anything disheartening unless there is absolute certainty as to the facts; *nil desperandum* and 'grin and bear it' are often the best if the last of prescriptions to be ordered. Mme. de Sévigné, in 1671, is said to have confessed, 'When one has deserved the gout, one should grin and bear it.' It is told of Erasmus Darwin, when

summoned to attend a wealthy person's family, where previously he had ministered to a fatal case, and so feared he would never be recalled, that he was informed, 'Oh, Doctor! you were the only doctor that gave us any hope.' 3. Without discussing medical details, advise well-chosen books on first-aid, home-nursing, hygiene, and infant-care, thus aiding to depose quackery. 4. Strictly observe the recognized canons of professional etiquette, and ever be ready to insist that they have been drawn up primarily for the benefit and in the interest of the public, in order that patients may be protected from the devices and desires of charlatans and empirics, and secondarily that the dignity of a learned profession may be maintained. Always inquire if a new patient is already under the care of another medical adviser.

Special Privileges and Duties.

In this country a qualified and registered medical practitioner is, in the eye of the law, somebody more than a mere private citizen; he has, in addition, a quasi-official status, which may at times connote certain public and private administrative functions. Being 'registered', he may, subject to certain self-imposed exceptions, sue for the fees owing to him for advice and materials of treatment; he may sign certain formal certificates, notably that of the medical cause of the death of a patient, whose body will not

be buried in a cemetery without the sanction of the district registrar of deaths unless this document is forthcoming; he may appear as an accredited and skilled witness in a court of law; he may hold specified public medical offices and receive the appropriate fees, from the enjoyment of which he would be otherwise excluded; he is exempt from forced jury service and militia training; humanity and custom condone the breach of recognized highway by-laws with respect to his riding and driving; his horses are not subject to be harnessed to the local fire-engine. He fails, however, at his peril, to notify certain events which have come to his professional knowledge, thus, infectious diseases, and it may be occasionally, in some areas, births. For the purpose of signing lunacy certificates and giving evidence at coroner's inquests the registered person must also be 'in practice'.

Public Officials to be known.

A medical practitioner should secure and maintain a professional acquaintanceship with such local medical and civil officials as may be of service to him and to his patients: the Medical Superintendent of the Poor Law Infirmary, the District Medical Officers and the Public Vaccinators, together with the Medical Officer of Health of the Local Sanitary Authority, are the chief public medical men; the Coroner and his officer, the Inspector of Midwives of the Local Super-

vising Authority, the Relieving Officers and Vaccination Officer, Sanitary Inspectors and Health Visitors (including School Nurses), the Police Inspector, the Registrar of Births, Marriages, and Deaths, and the Mortuary Keeper; and private inspectors, as of the Society for the Prevention of Cruelty to Children, should be known. It is well, also, to know personally the local Poor Law Guardians and County and Borough Councillors. Such of the above as have telephone numbers should be asked for the number, which should be recorded in the diary at once.

'As others see us.'

For an occasional self-review and self-criticism it is well for a practitioner to put himself in the place of (*a*) the patient under advice, (*b*) medical and other professional men in the same locality, and (*c*) the public, including the Press and the common jury.

(*a*) The obligations upon a patient are frankly to state the facts of his case, to follow the reasonable instructions laid down, and himself or by his executors to pay the fee within a recognized time. The patient expects from the medical adviser a practical knowledge which shall be given confidently, unhesitatingly, and consistently. At all times this function will require for its performance a measure of *savoir-faire*, so that the adviser remains at least just a little shrewder than a factitious or cunning patient, and so that he may en-

deavour to answer a fool according to his folly. Give and receive personal introductions and communications only by letter, never by word of mouth; at all times be wary against acting on hearsay evidence.

Women Patients.

In dealing with women patients a few generalizations are possible: never see them alone unless with an open door; whenever possible give directions to men, and never give personal instructions to a woman if her husband or father is equally useful and available; avoid treating married women unknown to the husband; send statements of accounts to the husband; never interfere between husband and wife, and in matters of matrimonial separation be sure that if the wife leaves the husband she will speedily return, but if the husband voluntarily leaves the wife he seldom comes back—women dislike lapsing into a frigid spinsterhood; always beware of giving occasion for accusations which may be the promptings of hysteria or worse; women are prone to make angry charges—they rapidly retract the accusation and screen the offender in cooler moments; women are more likely to exaggerate than are men; it is said that marriage increases criminal tendencies in women, decreases them in men. Married women in need of parochial relief may now apply to a relieving officer as 'heads of families'. When in doubt, or when the patient is

obviously dissatisfied, it is judicious to suggest at once an appeal to a higher authority, whom the patient may take some part in selecting upon your advice. Some patients it is well to see by a side door, which should only be opened to them as a special favour.

Threats and Blackmailing.

From time to time medical practitioners are the recipients of oral or written threats from those who are, or who feign to be, aggrieved. If a person threatens another with immediate personal violence, a constable may interfere and prevent a breach of the peace; every person is guilty of felony who accuses, or threatens to accuse, any one of a serious or infamous crime with intent to extort money or property. Such threats should be at once boldly met. Threatening letters are often sent by the insane, by practical jokers, by schoolgirls, and other foolish persons without any real evil intention. Whether signed or anonymous, they and the enclosing envelope should at once be handed to the police; prompt identification may easily result, and the writer may be warned or proceeded against. It is felonious to send or knowingly to cause to be received any communication actually extorting or intending to extort money or property by accusation or threatened accusation of serious offences. The gist of the offence is the object to extort money: the person threatened may be innocent or may be

guilty without the offence being different; the accusation threatened may be merely to a third person and not necessarily to the public authorities. In all these cases the threats should be treated as a criminal offence, and not as an occasion for compensation and silence. The action of the late Sir William Broadbent, when threatened by Neill Cream, in 1892, was the correct procedure: he handed the letters over to the police and then ignored the contents (*Old Bailey Sessions Papers*, 116, p. 1421). With all patients who threaten to blackmail or to take legal proceedings the best practice is to send in closing accounts at once, fees being fully charged, and to state that the communications complained of have been placed with the police or with the solicitor to your Medical Defence Society.

It is an anomaly which should be remedied that residence as an inmate of an asylum for the insane in no way excludes, even temporarily, the patient's name from the *Law List*, the *Medical and Dental Register* or the *Midwives' Roll*. Such persons are likely to commit legal offences in their professional dealings, owing to their unbalanced state of mind.

Relations with other Professional Persons.

(*b*) The relations existing between professional men, whether of the same or of different calling, should always be conducted according to the ethical code observed by the highest exponents of such relations.

Only recognized members of a profession should be taken into consultation. Peter Mere Latham long ago urged the need of men in practice abstaining from writing books or publishing articles in the lay press for the popular eye to read. If it is thought expedient to report what is considered to be unprofessional conduct on the part of another medical practitioner several courses are available: a Medical Defence Society may be asked for advice; the Ethical Committee of the British Medical Association may be urged to write and warn the offender; the licensing bodies from whom the unprofessionally-acting diplomate gains qualification may be appealed to: the Royal Colleges have great power, but the English Colleges are loth to act; the Universities are powerless. Finally, the General Medical Council may be approached; this body acts strictly upon precedent, and is particularly severe on 'covering', canvassing and advertising; it may caution offenders or remove their names from the Medical Register. The General Medical Council has no power over unregistered practitioners.

The members of the medical profession may be called upon to assist lawyers in public and in private. In the former instance they will be in the position of medical witnesses with either common skilled evidence or expert testimony. In the latter they will be called upon to inform counsel of certain pertinent professional and technical facts and possibilities, and

to advise the selection of appropriate experts. When a solicitor hands a case for an opinion to a barrister, it consists of (*a*) a narrative of the circumstances, in order of the time of occurrence, with copies of documents appended; (*b*) precise questions counsel is requested to advise upon, 'and generally to advise upon the case'; and (*c*) the solicitor's notes of any facts which may occur to him. The main function, in this connexion, of counsel practising in chambers is to advise upon the evidence which should be forthcoming, and to give a legal opinion on the case in question. In so doing the facts submitted must be analysed; the questions of law which arise must be considered, which may necessitate the framing of further queries; the changes in the relations of the parties in chronological order must be taken into account, if any such changes have occurred; and finally an opinion as to the merits of the case must be stated, together with the reasons. In giving his advice on evidence, counsel will detail the issues involved and then proceed to consider each issue specifically, and indicate what evidence will be necessary to fortify his client's position. The technical matters of fact he will need to be informed upon, the principles of law involved he will himself enunciate and apply. It is thus obvious that he should know as far as possible what technical facts can and what facts cannot be proved—that is, he should realize what

questions he can usefully propound to the medical men concerned.

Occasionally it may happen that, where a solicitor objects to enter a patient's room owing to a fear of infection, the medical adviser may be requested to be the bearer of confidential communications or to obtain a necessary signature.

Personal Publicity.

(*c*) It was the opinion of an ancient Greek dramatist, 'Hers is the greatest fame, not who is praised, not who is blamed, but simply who is not talked about.' This is also the ideal in so far as a medical practitioner and the Press are concerned: it may pay to pay to be left out of the newspapers. In all cases the 'fallacy of condensed newspaper reports' must be recognized and guarded against. Further, if it is suspected, without foundation, that certain facts have leaked out through the conversation of, or have been communicated by, a medical practitioner to the Press, this suspicion should be at once silenced by a personal disavowal of his having supplied the information. If imputations are made in public against certain acts of or treatment by a medical practitioner, he should protest, if he was not requested to be present or warned of the possibility of such remarks being made on such an occasion.

Clinical Examination for Medico-Legal Purposes.

Sir Henry Thompson used to affirm that the art of skilful cross-examination is as necessary in the case of patients as of witnesses. There is, however, one notable difference between these classes, for the medical practitioner, apart from the would-be insured and the wilful malingerer, has not to deal with hostile clinical witnesses. He can be candidly, and not merely apparently, frank and sympathetic with his patients. Usually cross-examination is conducted with a view either to weaken or to strengthen the effect of statements made just previously; a man obviously telling the full, plain, unvarnished truth is best left alone in the former direction. James Scarlett (Lord Abinger) confessed: 'I cross-examined in general very little, and more with a view to enforce and illustrate the facts I meant to rely on than to affect the credit of the witnesses—for the most part a vain attempt.' In the case of bad clinical witnesses—the shy, the ignorant, the incompetent, and the unobservant—cross-examination in its narrower forensic sense is serviceable when associated with keen observation. At its best, cross-examination must be fresh, original, and spontaneous; an eminent King's Counsel has said, 'A solicitor's notes for cross-examination are about the most useless part of a brief.'

The objects of a medical practitioner, when con-

sulted by a patient, are to ascertain the facts of the case, to deliver an opinion thereupon, and finally to convince the patient and secure his full confidence and obedience. Whether the last object has been attained will usually be obvious from the attitude and expression of the person advised: the play of the eyes and of the mouth is a good index. The medical adviser has hence to combine in his clinical practice the united functions of jury, counsel, and judge.

Effective cross-examination connotes in the questioner competence in technical knowledge. Although 'if you are not wise you should be clever', clever ignorance is dangerous, whereas knowledge applied is power, and power promptly exercised is the essential of success. 'You must know a thing before you suspect it, and you must suspect a thing before you find it' (Matthews Duncan). It follows that before a person poses as a specialist he should be a good general practitioner, and, further, that in extracting from patients 'the truth, the whole truth', it is well to comprehend in the interrogation and subsequent directions their minds, their bodies, and their estates —or at least their social states.

Clinical experience, personal and vicarious, has formulated certain working presumptions in the oral examination of patients. As was said of literature, 'the master may be known by what he omits' (Schiller). Diagnosis is not among the exact sciences, and brilliant

successes in its exercise may be criticized by professional rivals as feats of mere guesswork or as lucky random shots—'It sometimes takes an ignorant fool to guess the truth' (William Gull). Still 'all induction is a happy conjecture' (William Whewell), and 'depend upon it, a lucky guess is never mere Luck—there is always some talent in it' (Jane Austen). A man soon reveals his own depth of knowledge or ignorance of a subject by the questions he propounds, and often more information can be gained by listening well than by questioning overmuch.

The patient must be kept on good terms with himself and with his examiner: the popular names of diseases should be used; suspicion must not be manifested, otherwise masculine *amour-propre* or feminine self-sufficiency will be slighted; should it be necessary to disagree with a patient, the medical adviser must not become disagreeable, above all else he must keep his good temper. The questioner must avoid all open references to books or to notes during the actual examination—spontaneity begets confidence. He must also beware of the possible bias left by another recently examined case.

The Inspection of the Patient.

Whether in the consulting-room or in the sick-chamber, the medical examiner should place himself in such a position that a good direct light falls upon the

patient's face, while his own is shaded. Thus he may observe acutely and without embarrassment the play of the patient's eyes, mouth, and hands. It is well, however, to recollect that 'Being observed, when observation is not sympathy, is just like being tortured' (E. B. Browning). During the whole clinical investigation, both preliminary and systematic, the medical man must remember and apply continually the golden rule of Sir George Murray Humphry: 'Eyes much and often, hands little and seldom, tongue not at all.'

In order to abbreviate the oral inquiry, it is preferable for the consulting-room to be reached by a few stairs up from the waiting-room. The former apartment should be fairly long, so that, when a person has entered it, a glance may sum up his dress and address, his gait and attitude at rest, and any obvious appearance of pain or of distress exhibited by one whose limbs, lungs, and heart, all have been and are actively functioning. The exit from the surgery should not open into the waiting-room. Many questions may be spared if the family and the personal histories are already known, and again if the patient is able to answer for himself. The social and civil state, the apparent age and present health, the domicile and daily occupation of the patient, and the season of the year, may all be noted and silently correlated.

'Every face is a history or a prophecy' (J. K. Lavater). There is certainly much matter in aid of diagnosis in

a patient's manner; these 'so-called facts' and 'feelings' are a species of real evidence which greatly influence the opinions of observers, as, for example, with a jury. It must be remembered, however, that a perversion of Talleyrand's phrase sometimes may be true: 'The facial muscles were given in order to conceal our thoughts.' Excessive surgical dressings often have been used to influence a jury's sympathy. The medical examiner at times should see and feel (*via* the pulse), as well as hear, the answers to some of his questions; thus he may be able to test the credibility of the oral replies of a patient and discover a malingering or an hysterical affection. It is important to note not only what is said, but also how it is said. In clinical practice there is no place for the forensic maxim: *nemo tenetur prodere seipsum.* 'Pathology creates the doctor as distinct from the nurse' (Walter Moxon). 'The medical practitioner must base diagnosis not upon symptoms and signs as such, but upon the actual morbid organic conditions of which these clinical phenomena are the expression.' The physician must generalize the disease and individualize the patient.

Interrogation of Patients.

Prior to an interrogation, the preliminary inspection of a patient often will enable a medical examiner to sum up the objective signs of the physical or mental disorder; from the patient's own lips are secured the

subjective symptoms and the clinical history relative to the nutritive, excretory, and sexual, to the respiratory and circulatory, and to the neuro-muscular functions. 'Physician art thou? One all eyes?' Never must Sir William Jenner's maxim be forgotten: 'More mistakes are made, many more, by not looking than by not knowing.' It is wise to exercise a cautious scepticism with reference to all statements volunteered by a patient or by his interested friends, until, as Roderick Random was advised, you have submitted such statements, where possible, to the confirmation of 'occular demonstration'. Thus, never accept the hear-say testimony of a patient as to what another medical adviser is said to have said of the alleged disorder; never rely upon descriptions, by laymen or by nurses, with regard to tumours, bruises or wounds, evacuations and discharges, nor as to quantities which can be measured by your own hands or under your own eyes. 'Did you measure it?' is a question which you may have to answer later in public. See everything for yourself and give strict orders for specimens to be reserved for your personal inspection—'believe your eyes, disbelieve your ears.' 'Matters of fact are what we go upon, and all the rest is mere opinion.'

Should it be deemed necessary to put a series of questions, in order to clear up a doubtful point, let each query be single, simple, precise, orderly, purpose-ful, and, wherever possible, sufficiently wide in scope to

embrace all probable maladies of all the major organs. The desirable result of an exhaustive system of interrogation is twofold: there are fewer omissions possible and the replies are remembered more easily; time is also saved.

Assume what you can with safety. In this way the confidence of patients will be secured, for they may be strongly impressed by your apparently great acquaintance with their complaints. Do not pose as a thought-reader, however, for that *métier* is fatal to clinical popularity. Do not digress from the matter in hand, unless deliberately. Avoid generalities and extract definite, indisputable facts, such as actual dates, numbers, sites, &c. Omit all unnecessary or useless questionings, which, when answered, are unlikely to influence your judgment. Do not ask embarrassing, suggestive, or leading questions unless in immediate confirmation of your strong suspicions. In tracing some matters, as in obtaining confessions of guilt, the game may not be worth the scandal. If asked an awkward question by a patient, reply by asking something else. Beware of repeating a question already answered: an exhibition of such a lack of professional attention and courtesy wastes your own time and, what is much more serious, such a lapse of memory deservedly loses the respect of the patient. Falstaff's 'disease of not listening' is unpardonable in the clinician.

It is worse than foolish to make verbal inquiries on

a point which mere observation should settle, e. g. the presence of a wig, an artificial eye, or a denture. Occasionally it may be well to veil a very pertinent query among a number of apparently trivial inquiries.

Female Patients.

With female patients the physiology and the pathology of the sexual apparatus is much more prominent symptomatically than with males. Several generalizations are possible with respect to suffering women—who so often become long-suffering women—which are worthy to be remembered: they speedily mention any pain which afflicts them; a plump patient has no radical or organic disorder; they have a great tendency to exaggerate and to manifest self-sufficiency (cf. the very characteristic narrative in St. John iv. 29: 'all things that ever'); to suggest that an 'easy labour' was experienced is to merit contempt. The presence of a wedding-ring implies a woman who has been married—or who should have been. It is preferable to inquire early in the interview if she has ever been pregnant. This is better than first asking either: Are you married? or, Have you had a family?

When it is necessary to have clothing moved or removed for an inspection, this should be ordered as a matter of course, and not apologetically requested; herein is a change from the habits of our forefathers.

Women are, as a rule, much more tenacious of prejudice and sensitive to innuendo and apparent slights than are men; to extract full and faithful information the medical investigator must not lose the female patient's confidence in the slightest degree.

The Law requires that, previous to interrogation or to physical examination, a person, who may be under accusation, shall be informed that anything that may be said in reply or exhibited to the questioner may be deposed in Court and may be used as evidence against such person. Thereupon the person may decline to be examined or may request additional professional advice, for which he or she must pay.

CHAPTER II

MEDICAL EVIDENCE AND MEDICAL WITNESSES

This section deals chiefly with proceedings in the Coroner's Court. Every legally qualified and registered medical practitioner who is at the time in actual practice in or near the place where a death happened may be summoned by the Coroner to give medical evidence as to the probable cause of death (the Coroners Act, 1887). In this way medical men may be compelled to practise in items of medical jurisprudence if called upon so to do. With the growth of knowledge and of exact observation the weight which is attached to medical evidence has increased proportionately. It is still true, however, that 'the exercise of a sound judgment, which is of far more value in medico-legal matters than all the substance of all the ancient *Medicina Forensis*, must be our guide' (Casper).

The Coroner's Court differs from other tribunals in that, primarily, its president conducts an inquiry in which there are no formal parties opposed. In practice, the evidence admitted by this Court is on that account

much less bound by technical rules; thus, the Coroner and the inquest jury may apply any private knowledge they have acquired.

Medical Witnesses.

There are two classes of medical evidence and medical witnesses:—

1. The evidence of common witnesses of *facts* which they have personally observed. Such witnesses state the minor premiss of the forensic argument. A medical man may be called as a common witness of some event, usually he appears as a skilled common witness, able to describe in a technical manner matters which he has seen while qualifying himself to give the evidence. The patriarch Job's 'I shall see for myself, and mine own eyes shall behold, and not another,' indicates the correct attitude of a common witness of fact.

2. The testimony of expert witnesses concerning their *opinions*. They state the major premiss of the syllogism, whose conclusion is found in the verdict of the jury. No man can be compelled to offer opinion-evidence; all expert witnesses should be skilled witnesses. Expert evidence may be associated with common evidence when relative to an exhibit produced and described in court. Medical men, called to give evidence as to facts observed, must beware of being unconsciously drawn into offering expert opinions upon matters in dispute. As an opinion

may be requested of a medical witness, he need not leave the court when all witnesses are ordered out, for he should be acquainted with all the facts before he can frame a just opinion.

Notification to the Coroner.

In order to save the friends trouble, the Coroner should be directly notified of every death as to which the medical adviser is unable to sign a certificate as to the medical cause. The Coroner is bound to hold an inquiry after such methods of death. Such are the cases of persons found dead; persons whose death was probably hastened by accident or injury; persons who have died without recent medical advice, or who, although attended by a registered medical practitioner during the last illness, have died in such a manner, or at such a time, that the medical practitioner either is unable to assign a cause of natural death, or for some good and sufficient reason declines to certify the fatal cause. If you decline to sign a certificate, and fail to inform the Coroner of the case, the inquest jury is sure to wish to know the reason, although the Registrar-General has stated that the medical profession is 'under no obligation to report cases to the Coroner' (Nov. 29, 1889). It is usual to report to the Coroner the deaths of persons who die within twenty-four hours of being admitted to an institution. Most of

the cases in which you give medical evidence are those in which you have declined to sign a certificate of the medical cause of death; there are also those cases in which the relatives or others may complain to the Coroner of your treatment, and those cases in which the local or central Registrar of Deaths, and very rarely the Medical Officer of Health, refers your certificate to the Coroner for his scrutiny and action. Occasionally you may sign a certificate without viewing the body of the deceased patient, and later may learn in the Coroner's Court that an accident, unknown to you, accelerated the death.

The fact that the account for professional services rendered is likely to be unpaid is not a 'reasonable cause' either for publishing the nature of the patient's malady or for refusing to sign a death certificate. No fee can be claimed for this signature to the original certificate.

Even where a person dies as the result of a somewhat remote accident, which happened more than a year before the death, it should be reported to the Coroner. An inquest was held in 1882 on the body of a man who had been in Guy's Hospital for eighteen months after an injury sustained while diving into a swimming bath.

The peculiar and ancient office of Coroner has doubtless had its influence upon the unique respect for the value of human life to be found in this country.

Qualifying as a Witness.

The preparation of the evidence to be given should be made carefully, as the facts may be widely published and reflect alternative credit or discredit upon the witness. Refuse to give medical opinions as to private or hospital patients unless their consent in writing has been secured. Volunteer no private information and express no opinion in public, especially in the Press, concerning medico-legal causes with which you are or are not personally concerned; otherwise you may be subpoenaed to support your published views without having seen previously the statements of claim or of defence. If you know facts which will aid the execution of justice by the prevention of crime, give a hint to the police either yourself or by a medical friend. Give information viva voce or in written communications marked 'private'. Avoid writing unofficial opinions. 'Do right, and don't write—then fear nothing.' Decline to give medical certificates, even with the consent of the party most interested, to solicitors' clerks or to police constables gratuitously and without their written authority for requesting such being shown. Demand a formal interview by appointment, during professional hours, with a responsible superior, if your services are requested; otherwise you may receive no fee. Information given

to the Coroner's officer or to the solicitor interested concerning a pending forensic dispute is privileged (Watson *v.* McEwen, 1905), as are statements made in court after the witness has been 'sworn'.

Should you receive threatening letters demanding blackmail, or otherwise without reasonable cause, at once have them placed in the hands of the police or of a reliable solicitor, if you are not already attached to a Medical Defence Society. Lord Ellenborough gave the following advice: 'Let this action be a lesson for all men to stand boldly forward—to stand on their character—and not, by compromising a present difficulty, to accumulate imputations on their honour' (see p. 11).

Do not fail to attend punctually after receiving a formally served subpoena, on peril of being fined and charged with contempt of court and of an action for resulting damages on the part of the litigant calling your evidence. If you must be absent, do not fail courteously to inform the court of the fact and cause thereof. Unless in self-protection, or at the request of patients, do not appear in court without having been served with a formal subpoena; in your absence a friend may be commissioned to watch the proceedings if your professional action is likely to be questioned. You need not afford a *précis* of your evidence; the litigant must be satisfied with impromptu answers. If you appear at the request

of one side, do not divulge the nature of your evidence to their opponents. It is quite proper, however, to give a report to both sides if requested and the person concerned has no objection; it should be the same report, unless dated on different occasions. A fee for each report should be received. When in doubt or difficulty seek at once the best legal advice available.

'More mistakes are made, many more, by not looking than by not knowing' (William Jenner). You must be ready to meet an exhaustive interrogation on your depositions in court; hence it is essential that a careful clinical or post-mortem examination should be made and noted personally, with the aid of all reasonable modern apparatus, and that what is known professionally concerning the matters in hand should be revised from modern textbooks; your knowledge of therapeutics and pathology must be up to date. 'You must know a thing before you suspect it, and you must suspect a thing before you find it' (Matthews Duncan). You must be prepared to explain facts and very often conclusions to a body of more or less educated laymen; your language should be their language.

Remember you are not a partisan; value accuracy of observation and of statement as you do your professional reputation. Beware of confusing a previously formed inference for a real recollection of

actual fact—assumed conclusions sometimes fallaciously are made to suggest the apparent cause. 'The chambermaid, in the background, made out as much of the letter as she could, and invented the rest; believing it all from that time forth as a positive piece of evidence' (*Martin Chuzzlewit*). *Sit pro ratione voluntas* (Juvenal) is a fallacy to be guarded against.

Welcome and even suggest conferences with professional colleagues, which will avoid subsequent publicly expressed differences of medical opinions.

Decide what exhibits and sketches you will hand in; label, number, and initial them. If they are returned to you, preserve them for possible future use (e. g. pathological specimens). Previous to the trial keep all notes and exhibits under lock and key.

'My notes are not evidence without me' (Gurney, B.). Refresh the memory from your clinical or other notes just before giving evidence rather than when standing in the witness-box. Since 1824 any notes or entries in your diary read in the witness-box have been open to the inspection of the court; they must have been made by you at the time of the occurrence referred to or immediately thereafter—a fair copy may be objected to. You may use private signs and abbreviations in your notes.

Remember medico-legal evidence is subject to certain limitations—the 'facts' you relate may be

absolute or probable or merely possible, and hence opinions. (See Chapter VIII.)

Appearance in Court.

Having been duly subpoenaed you must appear punctually in court. Your functions will not commence there until you have been 'sworn'. All testimony offered prior to this formality is null and void, and not being privileged may render the speaker liable to an action for defamation of character. Should you have any objection to giving evidence, you must say so previous to being 'sworn', as your 'oath' will bind you when once it has been taken. Such objections may be:

(*a*) That your fee (for expenses and loss of time—for qualifying by personal examination and report) has not been paid by the solicitor calling you.

(*b*) That you are not qualified in the matter, and are unwilling to pose as an expert able to give opinion-evidence.

(*c*) That you may possibly incriminate yourself. If there is any possibility in this sense, the President of the court must formally warn you that you have an option in the matter.

'The Insanitary Oath.'

There is now complete emancipation from 'the insanitary oath', so that, if only for the sake of public example, you should decline to 'kiss the Book'

unless you have brought a private Testament with you, in which case you will usually be allowed to use it. Insist on your legal right to affirm or to swear by the Scots method. If you elect to affirm, say: 'I solemnly, sincerely, and truly declare and affirm that I will tell the truth, the whole truth, and nothing but the truth,' or, raising the uncovered right hand, say: 'I swear by Almighty God, as I shall answer to God at the Great Day of Judgment, I will tell the truth, the whole truth, and nothing but the truth.'

There is an incident recorded, after the Rebellion of 1745, where a Scots soldier declared: 'There's an unco' difference atween blawin' on a beuk, an' sennin' ane's saul to hell!'

After being 'sworn' all statements made as a witness are privileged. An action for slander is hence rendered impossible.

Do not, by gesture or expression, comment on an opinion given by another witness, but note any such manifestations in others.

Before actually commencing to give evidence your full name and address should be stated, then say: 'I am a registered medical practitioner'; your exact professional qualifications are usually immaterial.

The Manner of Giving Evidence.

The manner of giving evidence is worthy of consideration—for 'there is matter in manner'. 'Be the

plainest man in the world in the witness-box' (T. Blizzard). 'Tell the truth and make the truth tell' (T. T. Lynch).

Listen to the whole question propounded before you attempt to reply: then only answer what was asked. Make yourself understood and do not assume that the jury know all about the case and the causes; speak to them such language as if you were conversing in a friendly way with your gardener or coachman; say exactly what you mean; be candid, courteous, dignified, and withal good-humoured; speak with assurance, audibly, slowly, deliberately, and, in the coroner's court, with an eye on the recording clerk's pen. Avoid appearing to be suspicious: your personal disposition often counts more with a jury than your professional position: they will note such 'involuntary evidence' as looks, gestures, doubts, hesitations, confidence, calmness, consideration, or precipitancy (cf. 'Come, speak up, like an honest man!'). Use simple and popular words and terms, otherwise you may be thought to be speaking, as Carlyle said of Coleridge, 'either oracles or jargon.' Reserve technicalities for cross-examination. The jury will think they understand such terms as 'alcoholic disease of the . . .,' 'bad disorder,' 'black and blue,' 'black eye,' 'blood-clot,' 'blood poisoning,' 'blood-vessels of the neck,' 'bowel,' 'brain fever,' 'bruise,' 'buoyant lungs,' 'cancer,' 'consumptive spots,'

'coverings of the brain,' 'death stiffening,' 'great vessels of the heart,' 'gullet,' 'gut,' 'hardened liver,' 'hardening of the valves,' 'inflammation or congestion of the . . .,' 'overloaded with fat,' 'puffy,' 'shrunken kidneys,' 'skull-cap,' 'stroke,' 'swallow,' 'sweet-bread,' 'vessels of the neck,' 'windpipes.'

The technical rules of legal evidence are seldom enforced strictly in a Coroner's court. If you think it necessary, insist on answering double-barrelled questions: 'Yes *and* No.' Do not try to argue with counsel. An early 'I don't know' is far preferable to a late 'I did not know'. Be frank if the questions are beyond your knowledge; say at the start, 'I am not here as an expert and I am not being paid as such.' If you 'don't know', do not be trapped into guessing. Beware of argumentative figures. Remember also that a large experience is not all experience, and what you call 'a rare case' may reflect your limited experience. Don't exaggerate or estimate—'blessed are the pure in fact' in a law court; in measurements and descriptions be accurate and precise, quoting figures where possible.

The Matter of the Evidence.

As to the matter of the evidence you are called to give, certain facts should be kept constantly in mind. If you are unable to decide as to the medical cause of the death in question without the aid of a post-

mortem examination, tell the Coroner, and if necessary the inquest jury, at once; the most experienced pathologist will do so most often. If you deem an apology necessary in this connexion you may state that any internal organ of the body may be ruptured without external signs of injury being apparent. Without dissection the cause of death will be unknown.

Post and Propter Events should be clearly differentiated.

Distinguish what you have been told from what you have found by personal investigation. Notice if another witness in court gives exactly the same account as previously he gave you. A knowledge of the facts must not be confused with a knowledge of the records of those facts. State what you knew professionally as to the health and the habits of the deceased, but do not condescend to detail; it is sufficient to say, 'I treated him' or 'I prescribed for him'; you need not specify *how* unless required so to do by the President.

Don't offer any explanations unless directly asked so to do; decline to give 'expert opinion' testimony unless you feel fully competent so to do. You must, after being sworn, answer all questions put to you, excepting such as would tend to incriminate yourself; before you answer such questions you must be cautioned as to the option of refusal and as to the

possible legal results to yourself. There are recognized, in this country, no medical secrets which may be kept between a patient and his medical adviser when they are probed in a court of law; if, however, you have grave objection to answering on any point, appeal to be excused by the President of the court or hand up a written reply for his inspection.

Juries value evidence by the exactness of statement of, and the power of observation evidenced by, witnesses.

Think twice before adversely criticizing the opinion, diagnosis, or treatment of another medical practitioner, remembering that clinical symptoms and signs may have altered from day to day, thus explaining the apparent discrepancy.

In the higher courts textbooks written by living authors must not be quoted, for the direct oral evidence of such authorities can be procured; the authors and experts who support a certain view may, however, be stated. Counsel may quote passages from textbooks for your personal comment; when such a practice obtains strictly verify the text, the context and the date of the edition being cited before you affirm, modify, or deny the correctness of the views propounded.

Having completed your evidence, hand in personally the labelled and numbered exhibits which were provided by the police or discovered and prepared by

yourself. In the technical matter of chemical analysis, it is sufficient for you to produce the organs of the body properly preserved, and to suggest to the Coroner that he should have them analysed. There are obvious fallacies in utilizing 'real evidence', thus: 'Here's the note! I made it at the time!'—but *did* you?

The person of the Coroner's officer is always available for ocular demonstration to the jury of the site of injuries, &c. It may be wise to take, e.g., an anatomical skull into court for illustration.

If any important point has been passed over or omitted during the examination by a non-medical Coroner, volunteer the undisclosed information in your possession. Beware of being didactic on non-medical matters; such mistaken action is a fruitful source of the so-called 'differences of doctors'.

In concluding your evidence, state what, in your opinion, was the probable medical cause of death, especially assuring the jury if it was natural and if in all probability it could have been retarded if medical advice had been taken. Before leaving the box compliment, with due caution, the conduct of the police or other persons who rendered worthy 'first aid' to the deceased.

Notes and Reports.

'The best brief is a copy of the depositions' (Montagu Williams). When civil or criminal pro-

ceedings are likely to arise out of an inquest, carefully read over and correct where necessary your depositions as taken down by the recording clerk; having initialled any alterations the record must be signed as correct. Never sign a deposition handed to you without having perused it. As soon as possible after having given evidence write down the substance of what you said—this, with your originally prepared evidence, might be written for convenience of reference on the back of the official summons. In this way depositions can readily be identified later, when the evidence has to be repeated elsewhere. Counsel will then have scrutinized minutely not only the facts stated but also the facts as stated: he will be able to criticize keenly your second version if it is not identical with the original account.

In criminal cases the Coroner will bind over the medical witness by recognizance to appear at the subsequent trial and to give evidence. Usually cases with such witnesses are taken first in order at the Sessions and Assizes.

Before medical evidence can be afforded it will be necessary that the witness shall be qualified by having made certain examinations. In order to give such investigation its full value definite precautions must be observed.

'The best memory is a record made at the time' (W. E. Gladstone). Make a note on the spot as to the

person examined, the place, the date, and the hour of the commencement of the examination. Daylight should be chosen for post-mortem work and such a time that a complete inquiry can be made at one sitting, for, owing to the onset of putrefaction or other reason, another opportunity may not be afforded.

Where criminal charges may arise, associate the police (and, when necessary, the relieving officer) with the case at once, even before informing the Coroner. If called by a police-constable, note down his number (from his collar).

Decline, as early as possible, to attempt to execute technical processes which are probably beyond your skill: thus the Coroner will usually secure the permission of the County or Borough Council, or of the Home Office or Treasury, for expert analyses in suspected poisoning cases.

During the investigation exclude unauthorized lawyers and curious laymen, but, with the Coroner's permission, invite another medical man to be present, especially if your own previous professional conduct may be questioned later.

Whatever you discover must be kept secret until you give evidence in court. As a matter of courtesy, however, the Coroner may be informed confidentially, prior to the inquest, of any grave or unsuspected pathological discovery. Do not, however, inform

Press-men; disclaim in court the authorship of any 'facts' stated to have been found by you which may have leaked into the newspapers.

The medical examination of the living and of the dying for the purpose of medical evidence (the Metropolitan police-surgeons have a set of directions for the medical examination of prisoners).

All persons examined physically must be informed of and consent to the purpose and possible legal consequences of such inquiry. It is unwise, as a rule, to pretend to examine for one thing when really looking for quite another thing.

If possible, secure directions in writing from relations, officials, guardians, &c., but never act solely upon directions from such third persons (e. g. magistrates, police, employers) unless an injured person who should be examined is unconscious. If a further subsequent examination may be necessary (e. g. under an anaesthetic), that fact should be stated early. Witnesses should be within call or present in the case of the examination of a female.

Do not send written certificates to third persons as to the result of the clinical examination unless (1) the patient specifically gives you consent so to do; (2) the patient takes the certificate, which has been read aloud, in an open envelope for personal delivery. The payment of the fee for the examination by a third

person in no way absolves from the rule of professional secrecy or liability for defamation.

The symptoms and feelings complained of by a person being examined are sometimes admitted as (hearsay) testimony from a medical witness, especially if the patient is dead. Letters containing similar information cannot be put in as evidence. The admission of a patient's complaints to his medical adviser is one of the few exceptions allowed by a court of law to the rule which rigidly excludes hearsay testimony as valid evidence. Usually it is confined to the exclamations and statements made by an injured or sick person concerning the symptoms from which he stated he was suffering. It is by the aid of such information that the medical man arrives at his diagnosis and is able to decide upon a definite line of treatment. In 1906, in the Supreme Court of Michigan (U.S.A.), there was an unsuccessful attempt to enlarge the scope of this exception to the general rule of evidence. The victim of a railway accident called in the medical man who was retained as the permanent expert witness of the railway company in question; to him the symptoms were detailed, notably as to certain alleged localised pain and tenderness. It was held, in the subsequent action for damages, that to admit these statements in evidence would be a breach of the rule which excludes hearsay testimony; the Court was further of opinion that, even if the

patient's statements to the physician were received, the possibility of malingering would have to be discussed fully. Indeed, it was ruled that it seemed to be the design of the patient in making the alleged communications, to enhance the claim for damages, and that fact made them inadmissible for the reason that they were not the natural expressions of present physical sufferings, but voluntary statements for an ulterior purpose, and hence they were not within the allowed exception. In this country the occasions upon which a complaint by the person against whom an offence is alleged to have been committed is admissible in evidence are very few, apart from the above clinical exception; the complaint must refer to rape or to some similar offence against a woman or a girl, and must be made at the earliest reasonable opportunity, a matter which will be decided by the judge; the terms of the complaint are admitted in this connexion not for the purpose of proving the facts alleged, but in order to support the consistency of the prosecutrix and to negative her 'consent', although such a complaint would be admissible even where consent is immaterial; the fact that the complaint was elicited in reply to a question does not exclude its admission.

A confession (which must be quite voluntary) or a dying declaration (from the lips of a victim of homicide convinced of impending death) made in the

hearing of a medical man should be written down at once, word for word, and, in the absence of a justice of the peace, witnessed by the persons present at the time. Should death be imminent after a criminal assault, considerable discretion must be exercised in urging the victim to make such a dying declaration.

Persons committed to gaol or asylum should be followed by a statement directed to the medical superintendent by the usual medical adviser as to any mental or physical abnormality previously exhibited by them.

The Medico-Legal Examination of the recently or remotely dead.

In 1868 the Crown Office (Scotland) drew up a memorandum on this subject under the direction of Mr. Syme and Dr. Maclagan; this was revised in 1897 by Sir Henry Littlejohn.

The responsibility of ordering the removal of a dead body, even from his private surgery, should not be taken by a medical practitioner; he should leave it, after making a report, to the police or to the Coroner's officer. When called to inspect a dead body, however, the medical man should forbid any disturbance of the corpse and its clothes or its surroundings until he has seen them and the other pertinent circumstances. This precaution is, of course, impossible when a death has occurred in a busy

public place; in such a case the medical man should at once view the spot where the body originally was found, for marks of blood, &c.

The Coroner may order either 'evidence touching the external appearance of the body, and the cause of the death', or evidence after 'a post-mortem examination of the body'.

The body should be identified in the presence of the medical witness. If it cannot be identified, special care must be taken with the inspection of details; the finger-prints and a photograph should be taken at once.

The external appearance of the corpse, both when clothed and when stripped, must be noted. The probable time of the death must be estimated. The presence and nature of parasites and other diseases must be recorded. Should the probable cause of death still remain obscure after a complete inspection of the external appearances, the Coroner (and, if necessary, the inquest jury) should be informed of the fact, and should be requested to order a post-mortem dissection of the body.

A full autopsy is ordered as follows: 'You are required to make or assist in making a post-mortem examination of the body, which shall comprise an examination of the viscera of the head, chest, and abdomen, and, if necessary, an analysis of the contents of the stomach, and report thereon at the said

inquest'. As to the chemical analysis, see the Home Office Circular (January 7, 1903).

Since the Hounslow flogging case (1846) it has been the imperative practice not to open the body until the Coroner's order has been received: apart from inquests *super visum corporis*, it is necessary to obtain the consent of relatives of the deceased before the body is dissected.

Wherever manslaughter or murder may be alleged or is suspected, the Coroner nowadays will order a necropsy as a matter of course.

As a rule the body should not be opened until its surface is cold, but dissection must not be delayed so long that marked putrefaction has set in.

Before commencing, all the necessary instruments and appliances should be at hand, so that, having once started, there will be no need to leave the room until the final note has been made and signed. If the mortuary attendant acts as an assistant, he must not use a knife before the medical witness arrives, and each step taken must be watched by the latter.

It is unwise to employ a hammer or a chisel, for it may be alleged that fractures have resulted from their use. The external appearances of the corpse must be safeguarded: the face and the upper part of the chest need seldom be disfigured. If portions of organs are retained as exhibits or as specimens for subsequent examination, have the methods adopted in

taking and preserving them witnessed and recorded in the report.

It must be continually remembered that it is highly dangerous to attend lying-in women soon after making a post-mortem examination.

Rules as to Fees for giving Medical Evidence.

The medical witness has a claim for professional fees (1) for qualifying to give evidence, making an examination and a report thereafter, and (2) for attending in court to give evidence.

No fee can be allowed for merely volunteered information, given either in court or previously. The fee is due, even if evidence is not in fact called, when a medical witness attends in obedience to a summons *sub poena*.

Apart from an agreement to the contrary, an assistant or *locum tenens* must hand his fees (less incidental expenses) to his principal. Where public authorities compel attendance to give evidence in the public interest, definite fees are scheduled in the Home Office Order (1903) for such professional evidence in criminal proceedings. Where a private medical practitioner appears on behalf of a prisoner or a party to a civil action, an arrangement as to the fees forthcoming (preferably in writing) must be made, subject to taxation, between the solicitor and the medical witness.

1. In the Coroner's Court: No fee is payable by the Coroner for the preliminary inquiry and report to the Coroner; the police, however, are often liable for the first call; a fee is only allowed for evidence given or attendance at an inquest after a formal *subpoena* has been served. No fee is paid for an unauthorized post-mortem examination, although the facts so ascertained may be demanded in evidence without extra fee; a severe reprimand, indeed, will result if such a dissection is made. Usually, only one medical witness is called by the Coroner, and a second fee is not allowed for attending an adjourned inquest (L.C.C., 1895). When a practitioner, summoned to give evidence at an inquest, is sworn and gives evidence, and the Coroner then orders him to make a post-mortem, and the practitioner at an adjournment again attends and gives evidence, he is entitled to one guinea for the first attendance, and two guineas further for making the post-mortem and giving evidence thereon at the adjourned inquest. If any person state on oath that in his belief death was caused partly or entirely by improper or negligent treatment by a medical man, such medical man must not be allowed to perform or assist at the post-mortem, but he is usually permitted to be present. Travelling expenses can seldom be due to medical witnesses at inquests, as they are supposed to be practising in or near the place where the deceased died. In cases which present great difficulty, the

Treasury may send down recognized experts to assist the Coroner upon his request.

No fee for medical evidence (with or without a previous necropsy) is payable to the medical officer (whether honorary or stipendiary, visiting or resident) of a county or other lunatic asylum or of a voluntary medical institution in cases where the deceased died under the care of such officer. It is, however, not unusual to excuse such an officer's personal attendance at the inquest if he sends a report as to the facts to the Coroner. Where the deceased was 'brought in dead' to the institution the usual fees are payable to those who afford evidence; it is for the inquest jury, in case of dispute, to decide upon the evidence where the death actually took place. There is no general practice as to the inclusion or exclusion of certain institutions, but usually: *No fee is allowed* in the cases of Hospitals (including Cottage and Isolation Hospitals), Infirmaries supported by voluntary contributions, Asylums for the Insane, and Convalescent Homes; *A fee is allowed* in the cases of Parochial Workhouses and Infirmaries, Prisons, Barracks, Naval and Military Hospitals, Nursing Homes, Almshouses.

Fees. For giving medical evidence after an inspection of the appearance of the body, *one guinea*; for giving evidence after performing a post-mortem examination in accordance with the Coroner's order or under

direction from the majority of the inquest jury, *two guineas.* In case of dispute the appeal is to the County Court.

Penalty. The Coroner or the inquest jury may insist on a registered medical practitioner giving evidence and qualifying himself so to do, provided he is competent and has no other good grounds for refusal, under a penalty of *five pounds*; alternatively there is a penalty of *two pounds* imposable on all recalcitrant witnesses. Seldom are these powers enforced, and it appears that so long as the witness appears in court in obedience to the summons he can decline to give evidence if he has not already associated himself with the case.

2. In Criminal Proceedings: Evidence must be given although the fee has not yet been paid.

For skilled common witnesses at petty sessions or police courts, at quarter sessions, at the Central Criminal Court, or at the Assizes, certain maximum fees are specified: it is left to the clerk of the court to decide the actual fee in each particular case. For expert testimony or highly technical evidence the fee rests with the court or with the Treasury. For attending to give professional evidence in the town or place (that is, within a radius of three miles of the court) where the witness resides or practises: if the witness (1) appears in one case only, not more than *one guinea* a day, and that although a disagreeable examination

has been necessary in order to qualify the witness; (2) gives evidence on the same day in more than one separate and distinct case, not more than *two guineas.* For attending elsewhere, whether in one or more cases, not more than *two guineas* a day. No full-day allowance is paid unless the witness is necessarily detained away from his home for at least four hours for the purpose of giving evidence, otherwise he receives *half-a-guinea.* The fare actually paid by him is usually allowed to a witness as travelling expenses. A medical man, while sojourning in the precincts of the court, may be ordered by the President, in case of need, to assist with his professional services. In case of dispute as to the fee paid, the Home Secretary, Whitehall, S.W., should be applied to forthwith.

3. In Civil Actions: Here it is a matter for private arrangement between the medical witness asked and the parties requesting his services; he should be very careful not to interfere in the case before such an arrangement has been made. *One guinea* a day is usually regarded as a minimum fee; travelling money (which should be paid in cash before the journey commences) is additional. Before being 'sworn' in court, payment in civil cases can be insisted on, but having been 'sworn' the evidence available must be given. The solicitor is not personally liable for the expenses, for he is an agent acting on behalf of a disclosed principal.

The Employment of Medical Referees and Medical Assessors.

The English system of law is litigious, as opposed to the inquisitorial system by which many disputes are settled by officers before they arrive in a public court. One of the earliest examples of a medical referee being employed is in 1290, when the court, after being advised by physicians, directed the jury as to the legitimacy of a posthumous child. In 1345 where a recently inflicted wound was in question, a writ was issued to the sheriff to cause to come 'medicos, chirurgicos de melioribus Londinii ad informandum dominum regem et curiam de his, quae eis et parte domini regis iniungeruntur'. Similarly, Plowden records, in 1571, 'the judges of our law have been used to be informed by surgeons whether it be maihem or not, because their knowledge and skill can best discern it' (Buckle *v.* Rice-Thomas). Another instance of reference was where a woman, in cases of alleged pregnancy, 'pleaded her belly', or where a writ *de ventre inspiciendo* was issued; here, if the matrons selected could not come to a decision, it became customary to call in the aid of a medical man who, having thus qualified, was examined upon oath in court. The Regulation of Railways Act, 1868, is the first statute in which a medical referee is mentioned (see p. 131). The Regulation of Railways Act, 1871 (s. 8), directs Coroners in

England to send notice to the Board of Trade, who may appoint an assessor; since then Coroners have had the aid of experts and inspectors in most technical matters. The Judicature Act, 1873 (s. 56), provides for the trial of cases, 'other than a criminal prosecution by the Crown,' by qualified assessors. The Patents Act, 1883, gives power to the judge or to the litigants to demand an assessor. In the Admiralty Division, where there is seldom or never a jury and where no expert nautical witnesses are allowed, Elder Brethren of the Trinity House assist as assessors; the Probate, Divorce, and Admiralty Division is the only Division of the High Court which has an official shorthand record of its proceedings. The Arbitration Act, 1889 (s. 5), deals with the appointment of an arbitrator or umpire (s. 14) where 'scientific or local investigation' is advisable. Under the Workmen's Compensation Acts of 1897 and 1906 medical referees are appointed by the Home Secretary, subject to regulations made by the Treasury.

Under the later Act, where a medical referee has been employed in his private capacity in connexion with any case, he cannot act as medical referee in that case. When agreement cannot be arrived at between the 'workman' and his employer as to condition or fitness for employment, or to what extent the incapacity is due to the 'accident', upon application by both parties the registrar of a County Court will refer the matter to a medical referee, who, in accordance with

regulations made by the Home Secretary, will give a certificate as to such condition and fitness, or as to the extent of incapacity being due to the 'accident', and, when necessary, specifying the kind of employment for which the 'workman' is fit, and this certificate is final and conclusive (Regulations issued June 24, 1907, as to Duties and Remuneration of Medical Referees in England and Wales under the First and Second Schedules to the Workmen's Compensation Act, 1906). These duties being of a judicial character, it will be observed that the position of a medical referee is a very important one, and a medical man occupying this position will be wise in preserving an attitude of absolute impartiality; his skill must be unimpeachable. Further, the Act authorizes County Court judges to summon a medical referee to sit with him as assessor; and any committee, arbitrator, or judge before whom any case may be heard may submit any matter material to the issue for report.

CHAPTER III

MEDICAL CERTIFICATES AND MEDICAL REPORTS

The quasi-official status accorded to the qualified and registered medical practitioner gives him certain privileges in attesting facts and in affirming opinions as to the physical or mental condition of his own or others' patients. This privilege must be discreetly and worthily exercised, for in many such cases the written or spoken word of the medical adviser is regarded as a final and conclusive statement as to the health, present or possible, of the person in question. The power thus given to the medical profession to interfere by professional opinions in discussions as to the personal attendance in court, the liberty of person, or financial claims is to some extent supreme and beyond appeal, hence the responsibility undertaken in such circumstances cannot be too highly estimated. On the other hand, an honourable medical practitioner is justified in resenting any imputation as to the bad faith of his professional declarations, and be he in private practice or in a medical office, his course will probably be, in such an event, to protest and to wash

his hands of the whole business, and if possible retire. In institutions the directions of the medical officer in charge must be acted on forthwith; the ship's surgeon at times assumes control of the movements of the vessel even as against the master; the prison surgeon's views as to the mental or physical condition of his charges are respected—it has been suggested by the lay press that well-to-do prisoners sometimes have abbreviated their sentences via the prison infirmary; similarly, as Dr. W. B. Chowne stated in 1841, 'in the army, in the navy, and in prisons, the responsibility of remitting or of inflicting punishments is cast upon a member of the medical profession, to watch the progress and to judge the effect of the infliction upon the constitution.' A tendency of officialdom, long ago pointed out by Jeremy Bentham, is to ride rough-shod over schemes of professional etiquette, and in this particular a private medical certificate is at times freely criticized by the official medical man through whose hands it passes in the ordinary course. This tendency needs to be carefully guarded against now that the numerical strength of medical officials is so rapidly increasing.

As none is infallible, it is wise in signed statements always to insert in certificates as to the nature of a patient's malady 'In my opinion . . .' There can be no charge of perjury if an opinion as to what is really believed to be a fact is given, for it is impossible with

certainty to tell what is present in or what is passing through another person's mind.

Great caution must be exhibited not to exaggerate nor to add fiction or surmise in order to gratify an unscrupulous although persuasive patient. By yielding to his illicit desires the medical man becomes his tool, and, having played into his hands and being under his thumb, loses at once independence, and associated with that loss is diminished self-respect. Conversely, nothing must be extenuated nor anything set down in malice. As a corollary to this caution it will be well to see that, where it is possible, a patient for whom a medical certificate is signed, so conducts himself subsequently in public as to support the professional opinion formed and testified to.

Printed forms should not be signed until they have been carefully read right through, otherwise positive facts may be affirmed which are not justified upon clinical observation. There is a common tendency to read printed matter less carefully than manuscript.

In the superior courts it is necessary for a medical adviser to declare, in person and upon oath, his opinion as to the health of an invalid patient who is unable to attend, be the latter a witness, a juryman, or the person accused; in such cases it is not sufficient merely to forward a signed medical certificate as to the facts. When thus attending in person it is enough, as a rule, to state that the patient is too ill to attend court; there

is seldom a call to volunteer or to state the exact nature of the illness, although the probable duration of the illness may be demanded. All testimony by certificate is a variety of evidence on commission and as such has its recognized vices; thus it is never tolerated in criminal proceedings: it is not subject to cross-examination as would be the certifier if present.

There are many special and general points which should be observed in drawing up medical certificates and medical reports concerning patients:—

The person who signs should have made all the inquiry whose result is vouched for in the certificate; no medical man should certify what another person has found or is said to have found. Disputes occasionally arise as to whether the signature is that of the *usual* medical adviser or the *last* medical adviser of the person to whom the certificate refers (Huckman *v.* Fernie, 1838); it is a question of fact which the jury must decide. It is apparently not necessary that the *usual* adviser should be a registered practitioner; the person who acts in that capacity for the time being, whether qualified or not, is the person to give the required information (Everitt *v.* Desborough, 1829); probably since the *Medical Register* has been compiled this statement should be modified.

Occasionally a solicitor may desire to have substantiated by a medical man the death of a certain person for whom a certificate was signed; the follow-

ing affidavit should be made: 'I was well acquainted with the said A. B. He is the same A. B., the certificate of whose death is now produced (marked YZ) and shown to me.'

The facts and the opinions stated in the certificate or report must be accurately and precisely set out. Only such facts as have been found by personal examination should be certified, otherwise the formulae should be used either: 'I am informed by the patient that . . .' or 'I am of opinion that . . .' A signature must never be appended to an unverified statement of alleged facts in order to oblige a medical colleague, as a deputy, or as a friend: the one who signs is responsible, both for prescriptions and for certificates, should untoward results be brought about by their deficiencies. Never sign as to what another qualified person's examination is said to have discovered. Similarly, a number of blank but signed certificates should never be left for the use of a partner or a *locum tenens* during temporary absence from home.

What has been written should be carefully read over before the signature is appended.

Unless a person requiring a medical certificate has been notified to the contrary on taking office, it is not necessary to state the nature of the complaint—cf. the case of school-teachers and children under the L.C.C. School Management Code. Words must not be used in certificates which would affect the character and

reputation of the person concerned; thus words of reproach, 'pauper,' 'prostitute,' 'lunatic,' should be guarded against. In reporting to public bodies technical terms are best employed—cf. the Poor Law Consolidated Orders, instructions to Medical Officers entering up Infirmary Books (Art. 205, 4). The certificate must be accurately dated, if a day other than that of the day of signature is recorded legal proceedings against the certifier may result (see *The Law Times*, 1904, p. 447). In certificates and reports which are required periodically, the patient must be seen each time before a statement as to his 'present condition' is made, otherwise risks may be run of appearing to deceive others owing to the certifier himself being deceived personally. Similarly diagnosing and prescribing by telephone should rigidly be avoided.

Where possible, official printed blank forms should be acquired and used.

For whom a certificate is written is a matter of very practical importance; carelessness or ignorance in this connexion may result in legal proceedings. Certificates of health are written primarily for the patient's use, although they may be demanded in fact by a superior authority having control over the patient. Hence such certificates of health or sickness must only be signed with the examinee's full consent. Apart from certain official relationships, where the person examined may be presumed to know that the

certificate will be placed in other hands, it should be remembered that a medical certificate is a confidential document, and should only be written at the request of the person examined or of one who stands *in loco parentis* to such person. Such certificates should never be given as a matter of course, but only in response to a definite request. In cases where a direction from an employer is acted upon, even with the consent of the person sent and examined, the certificate required should be read over to the person whom it concerns, and given to such person, who may then do with it as seems best to him or her. It is best to hand it enclosed in an open envelope, saying 'Take this!' rather than to suggest, 'I will send it by post at once!' This rule is in no way weakened by the fact that the employer pays the fee for the examination and the opinion. Similarly, the police or solicitors are not to be informed of medical confidences without the full consent of all parties interested; this caution applies quite as much to hospital as to private patients.

In cases where certificates have to be provided by statute without a fee, that condition only applies to the original certificate; a fee can be charged for copies. Whenever a certificate is given and no fee is claimed, it should be suggested as a personal favour.

Drawing up a Medico-legal Report in case of Death.

In most cases the medical witness must recite the report in open court, occasionally it may be received on affidavit. For a complete investigation three sets of facts must be collated:—

1. The details of the surroundings of the dead body, when and where first seen.
2. The personality and personal history of the deceased.
3. The results of an exhaustive external and internal post-mortem examination.

a. The Manner of the Report.

The report should be written or type-written on one side of foolscap paper, a wide margin being left. The sheets and the paragraphs should be numbered: this facilitates reference. Names and figures must be written plainly and underlined, as should the words 'right' and 'left' when used; this aids accuracy of description. Care must be taken not to confuse anatomical with topographical descriptive relations. Quotations should be included in inverted commas.

Reports should be short and distinct; all unnecessary words should be omitted, with the adage in mind, however: *Brevis esse laboro, obscurus fio.*

Technical terms should be used only when the

report is intended for a public authority; otherwise, if and when used, they should be explained in popular language.

Exclude irrelevant and uncalled-for reasons, opinions, and comments. 'The *sometimes* of the cautious is the *often* of the sanguine, the *always* of the empiric, the *never* of the sceptic; but the numbers 1, 10, 100, 1,000 have but one meaning for all mankind.'

'Science is measurement.' Everything that can be should be measured precisely. Anatomical, pathological, and chronological order and exactness should be aimed at. It is worse than fallacious to say 'There is no . . .' when 'I can find no evidence of . . .' is meant. Similarly, it is better to say 'There is no sign of injury' than 'There is no injury.'

To assist an immediate comparison, easily recognized British standards should be quoted.

In important cases the report should be typewritten in duplicate and signed, one copy being handed to the President. Any additions to or variations of the report made during the examination of the witness should be noted and initialled by him. Where two or more persons sign a report, the order of signature should correspond with the order of seniority of qualification as shown by reference to the *Medical Register*. In signing a report, the date and medical qualifications should be recorded. It may be well to have appended the signatures of other

medical men who may have been present; none such should be admitted unless they produce a written permission from the Coroner. Reports should be kept under lock and key for safety.

b. The Matter of the Report.

The date and time of day of the commencement and the completion of the examination and the names of all persons present thereat should be recorded.

There must be a very sharp division made between—

Information received and from whom—this is hearsay—and *facts found by personal examination* or under personal supervision.

The results of a complete methodical external (anterior and posterior) and internal anatomical investigation must be detailed. The state of the diseased organs and their contents may be recorded first, then the healthy organs may be enumerated, as such, exhaustively. After entering all the pertinent facts, summarize the main points, and conclude with the probable cause of the pathological conditions found.

Append any sketches, photographs, or descriptions of exhibits, carefully numbered, which elucidate the case.

Retain an identical copy of the report for personal reference.

Medical Certificates.

Most of the authorized certificates and forms which a registered medical practitioner may be called upon to fill in and sign will be found enumerated below. A medical adviser continually must remember that, if consulted with reference to his patient's private affairs, he should never give more than general friendly advice: it is for a solicitor to act. All medical certificates and reports should be kept under lock and key.

a. Certificates met with in General Practice.

I. Compulsory (under penalty).

No fee recoverable. A certificate of the medical cause of death of a patient must be given in ordinary cases, although the fees due may be unpaid and likely to remain so. This certificate may be scrutinized by the Registrar, the Coroner, and the Medical Officer of Health. The Coroner must see it under (1) the Inebriates Acts, 1879–1900; (2) the Infant Life Protection Act, 1897; (3) in the case of the insane who die in institutions. The Sheriff, for purposes of identity, must see the certificate of the prison surgeon after capital punishment. If a duplicate certificate of the cause of death is required by relatives a fee is chargeable (but see Friendly Societies' Act, 1896, s. 6).

Failing others so doing, the medical practitioner present at birth or at death must notify that fact to the Registrar (Births and Deaths Registration Acts, 1874) and to the Medical Officer of Health within thirty-six hours (of birth or 'still-birth') where the Notification of Births Act, 1907, is adopted.

Certificate of insusceptibility (Form D) or of successful vaccination (Form E, Vaccination Acts, 1867–1898) is given to the parent or to the Vaccination Officer.

Fee allowed.

Information ('on becoming aware', 'in my opinion') under the Infectious Diseases (Notification) Act, 1889, to the Medical Officer of Health (fee, 2*s.* 6*d.*; if notified from a public institution the fee is one shilling only). Reporting poisoning by arsenic, lead, mercury, phosphorus, and anthrax, under the Factory and Workshops Act, 1901, to the Home Office (fee, 2*s.* 6*d.*; official form optional).

Signing depositions made before Coroner when called as a skilled common witness (fee, £1 1*s.*).

II. Optional.

Nomination of and voting for direct representatives on the General Medical Council (England, three; Scotland, one; Ireland, one).

Certificates of personal health (reports, medical evidence in civil cases, affidavits and statutory declarations under Act of 1835).

Physical: as to general health (illness, disease, or convalescence; accident or injury; ability of child to attend school, or 'special school'; health of witness or juror—in superior courts personal attendance replaces certificate); postponement of vaccination (Forms B and C) to Medical Officer of Health; impotence, sterility, sex mistaken at birth.

Mental: after examination of alleged insane; imbeciles; mentally defective children; testamentary and contractual capacity.

Certificate (on form provided) of cause of death and duration of last illness of a deceased policy-holder (with or without a necropsy) for a Life Insurance Company.

Written report to Coroner to facilitate inquiries as to (1) suspicious deaths, (2) the results of an autopsy, (3) circumstances of deaths under anaesthetics or after operation.

Signing Form B under the Cremation Act, 1902.

Certificate for burial after 'still-birth' under the Births and Deaths Registration Act, 1874.

Certificate stating that a person suffering from a dangerous infectious disorder should be removed as he is 'without proper lodging and accommodation'.

Certificate of necessity for disinfection of private apartments.

Certificate for presentation to the Justices for the removal of a corpse to a mortuary after an infectious disease under the Public Health Act, 1875 (s. 142).

Certificate for prevention of such a body being removed from isolation hospital unless for immediate burial under the Infectious Diseases (Prevention) Act, 1890.

Attesting a 'dying declaration' when formal depositions are impossible.

b. **Those arising from the holding of a special office by a Registered Medical Practitioner.**

In the Naval, Military, or Civil Services (various).

In the Local Government service: Medical Officer of Health, of Education, Public Analyst, Poor Law Medical Officer (District Medical Officer, Public Vaccinator, or Medical Superintendent), Inspector of Midwives.

As a Certifying Factory Surgeon under the Factory and Workshops Act, 1901.

As a Medical Referee under Workmen's Compensation Act, 1906.

As being able to sign Form C under the Cremation Act, 1902.

As a Medical Examiner for life assurance or superannuation purposes, as to past and present state of health.

CHAPTER IV

THE LAW OF DEFAMATION IN RELATION TO THE MEDICAL PRACTITIONER

A MEDICAL man is primarily a citizen, and thereby a subject of the general common law of the land; but the State, by indirectly granting him a licence and registration, recognized him as having a special status, a position which carries with it special privileges and special responsibilities. The relations between A. B. C., Esq., and Dr. A. B. C. are often difficult of definition, and have led to great discussion, and it is for the consideration of some of the results of this peculiar relationship—the rights and duties arising therefrom—that this chapter has been written. In sum the law of defamation applies to Dr. A. B. C. generally, as to all other citizens, and specially, as to a medical man.

In England there is no actual Act of Parliament which confers upon the citizens of this country the right of freedom of discussion and expression of opinion, for this right is a corollary from the general law of the land. '*Our present law permits any one to say, write, and publish what he pleases; but if he make a bad use of this liberty he must be punished. If he unjustly attack an individual the person defamed may*

sue for damages; if, on the other hand, the words be written or printed, or if treason or immorality be thereby inculcated, the offender can be tried for the misdemeanour either by information or indictment.' This is a comprehensive statement of the law of defamation by its classical exponent, Dr. Blake Odgers, K.C. In a State trial it was said, '*The truth of the matter is very simple when stripped of all ornaments of speech, and a man of plain common sense may easily understand it. It is neither more nor less than this, that a man may publish anything which twelve of his countrymen think is not blameable, but that he ought to be punished if he publishes that which is blameable, i. e. that which twelve of his countrymen think is blameable.*' So that if a dozen of your fellow-citizens empanelled in a jury consider, after hearkening unto the evidence, that you have publicly and maliciously defamed some one's character, you will have to pay a penalty for the defamation you have published; if from another you publicly filch his good name, it may enrich him and leave you poor indeed. Technically, publication means making public, it may be to the whole world, or it may be merely to one stranger. If the defamation was vivâ voce it is *slander*, but 'a false and unprivileged publication in writing, printing, picture, or effigy, or other fixed representation to the eye which exposes any person to hatred, contempt, or ridicule, or which causes him to be shunned or avoided, or which has a tendency to injure him in

his occupation,' is a *libel*, and is properly considered as a more serious offence than slander. The position of permanent phonographic record has not yet been raised.

The varieties of defamation may be instanced thus:—A person may shout or tell his friends, 'Dr. X. is a quack,' or he may write that legend on Dr. X.'s gate, or send him a post card to that effect, or even draw around the streets a 'guy' purporting to represent Dr. X., so making him ridiculous; each act is defamatory.

Libel and Slander.

The legal attributes of the two possible forms of defamation differ. Slander is considered as less culpable than libel, for *verba dicta pereunt*, but *literae scriptae manent*. Transient words are often spoken thoughtlessly, as in a rash moment of anger, but permanent writing seems to imply some cogitation precedent to the publication of the libel; and further, it is sufficient effect for an action of libel if '*a fixed representation to the eye*' brings the person defamed merely into hatred, contempt, or ridicule, whereas some actual pecuniary loss must be substantiated as the direct consequence of the alleged slander, unless the imputation is of such a nature that a jury may infer damages as a necessary consequence. Again, generally speaking, unless actionable only by reason of special damage, an action for slander must be brought within two years of

its publication, whilst six years may elapse before an action for libel dies. As gross libels (blasphemous, obscene, seditious, or those in the nature of a challenge) often tend to cause a disturbance of the King's peace by those grossly libelled thereby, they may be dealt with as *criminal* acts. But words obviously and palpably out of proportion to the occasion (*e.g.* election epithets) may fail to be sufficient for an action, the Court regarding them as mere vulgar abuse, and hence unlikely to harm the person at whom they are directed.

The rule that a consequent special pecuniary loss must be proved successfully to uphold an action for slander is probed by several exceptions, which are especially interesting to members of the medical profession. Thus if you vivâ voce impute to a person (1) a crime which, if proved, would involve imprisonment or other corporal penalty; (2) a present contagious or infectious disease of a definite kind: thus Blackstone (1794) cites plague, leprosy and *lues venerea* as actionable because of the connoted imputation; past infection being alleged is not actionable (Bloodworth *v.* Gray, 1844); 'he has the pox' is assumed to mean variola unless the context infers syphilis; (3) unchastity or adultery in a female; or if (4) you make statements alleging bastardy, so tending to the disherison of the plaintiff, an heir apparent: the person defamed is not bound to show that actual loss has been suffered as the result. On the other hand, if X. publishes statements

directed against your technical fitness and competence in your professional calling, you need not prove a subsequent actual monetary loss in support of your action for slander against him. You may, of course, defame another by, so to speak, *oratio recta*, in which you express your own personal opinion, or by *oratio obliqua*, in which you relate what somebody else said of him, for in each case you are the means of publishing the opinion. Lastly, an *individual* must be defamed. A profession as a whole can no more be defamed than can a nation be indicted; similarly no action could be founded on the statement of Gil Blas, who, being taken ill during his travels, puts up at a village inn, and narrates: 'But there being no doctor in that village I soon got better.'

Defences.

The lines of defence to an action of defamation of character are threefold; when set up they must be put upon the record.

1. A technical publication may be denied.

2. Publication may be admitted, but the plea of justification may be set up, on the ground that the whole statement was true in substance and in fact. 'It is insufficient to be partly right merely in defamatory statements,' nor is it sufficient to plead that the defamer believed them to be true. If the plea of truth fails the jury is inclined to enhance the damages; the

Court of Appeal, however, protects against vindictive damages inflicted by an inferior authority. Such a plea is always a sufficient answer to a mere action for damages, but it must always be shown, if the defendant wishes to avoid all penalty, that the occasion warranted that statement, which was not used as a means of exhibiting malice or personal bias. Thus criticisms must not go beyond fair and bonâ fide comment on matters of public interest, and your certain knowledge of a fact detrimental to another's reputation does not allow you to take the world into your confidence; for to publish statements which, though perfectly true in themselves, tend to damage an individual without being of any benefit to the public, is punishable criminally. It is not sufficient to allege that the public is 'simply interested in knowing the gossip about their neighbours'. It was in such a case that Lord Mansfield said, 'The greater the truth, the greater the libel.' It is the province of the judge to decide what is in the public interest; the jury deals with 'the influence of malice', the presence or absence of *mens rea* being a question of fact.

3. Or privilege may be pleaded in respect to either the occasion (forensic privilege) or the communication (professional privilege). It is a matter for the judge to decide whether the occasion when the statement was made is privileged. Cases are referred to later where the privilege is absolute, and where it is merely

qualified; in the latter case the plea avails not if it can be shown that malice prompted the defamatory statement. The defence of privilege may merge into that of justification.

Turning now from the osteology, so to speak, of the question, we come to the every-day facts which clothe these dry bones of the law before they appear in public; from the general statement of the law of defamation of character we proceed to its special application to the qualified registered medical man. At once we are confronted by a double aspect; the medical man may either be wronged or be wrong, he may be passively defamed, or he may himself—often, be it said at the outset, unwittingly—be the active defamer. It is this latter aspect which demands as a practical rider a consideration of the great question of the proper limits of professional secrecy and confidence, and the extent of the privilege allowed by the law in cases involving this factor; there are cases when the practitioner feels it a public duty to say something about somebody and to remove his finger from his lips.

Defamed Practitioners.

Firstly, then, in what cases is a medical man, as such, likely to be defamed and injured professionally? and secondly, into what pitfalls may he project himself in referring to his patients or to his brother practitioners?

Of the many cases which might be chosen to illustrate the malicious defamation of a medical man as such, the following are not without interest, thus:

To advertise falsely that certain quack remedies —'Sir James Clarke's consumption pills'—were prepared by an eminent physician was sufficient to be regarded as a libel against that physician as an imputation of unprofessional conduct (1848). A medical practitioner, however, cannot restrain the use of his name by others unless the publication is defamatory or injurious to him in his property, business, or profession.

In 1904 it was held to be libellous to publish an advertisement stating that a named person had been cured of a certain disease by a certain drug.

Again, when an American M.D. published part of his treatise on an infallible 'consumption cure'—the inhalation of oxygen—in the advertisement (!) columns of the *Times* newspaper, the *Pall Mall Gazette*, criticizing his effusions, called him 'an impostor and quack', and said he was like 'scoundrels who utter this base forged coin', the jury, in the action for libel, only allowed him one farthing damages, as they considered the remarks little more than fair and bonâ fide comment on a matter of general public interest (1866). The limits to which such comments may extend are stated in the following quotations:—'A critic must confine himself *to criticism*, and not

make it a veil for personal censure, nor allow himself to run into reckless and unfair attacks merely from the love of exercising his power of denunciation.' 'Whatever is fair and can be reasonably said of the works of authors, or of themselves as connected with their works, is fair comment and is not actionable, unless it appears that under the pretext of criticizing the works the defendant'—in this case Mr. Thomas Wakley—'takes an opportunity of attacking the character of the author: then it will be libel.'

It is libellous to say in print of an unqualified medical man that he is 'the Harley Street quack, physician extraordinary to several ladies of distinction . . . female destroyer' (1831); but it is *no* libel to write and publish of a physician (as in the case arising in connexion with the death of the Earl of Beaconsfield) that he has met homoeopathists in consultation, notwithstanding it be averred in the declaration that so to do is a breach of professional etiquette, for the Medical Act (1858) declares 'the name of no person may be removed from the Register on the ground of his having adopted or refrained from adopting the practice of *any particular theory of medicine or surgery*'.

In the following instances a *proof of special damage*, i. e. financial loss, was held to be unnecessary to support successfully an action for slander:—

When accusations were made against a medical

man that a patient died 'because of his ignorance' or culpable negligence, and in a similar case that he administered medicine in excess, or wrong medicine ignorantly or unskilfully; for, as Chief Baron Pollock —one of 'the Last of the Barons'—once said, 'it would be most fatal to the efficiency of the medical profession if no one could administer medicines without a halter round his neck.' Again, where a qualified medical man was defamed as a 'quack-salver', as an 'empiric mountebank', and where A. said to B., referring to B.'s doctor: 'He is a bad character; none of the medical men here will meet him.'

To support the action in the following cases it was necessary for the plaintiff to prove as well pecuniary loss, as the names of specific patients who forsook him, thus causing a diversion of fees from his pocket:—

When one said 'he did poison the wound of his patient', for the Court hinted that the poison alleged might have been a proposed means of cure. So general accusations of 'malpractice', without affirming a specific and consequent injury or death; calling an *un*qualified man a 'quack' or 'impostor', and accusing a medical man of laxity in his purely private as distinct from his professional life, must involve demonstrable special damage to be successfully actionable, for there is here no reflection on his professional skill.

Practitioners Defaming.

The second aspect of the subject is: How may a medical man by his own statements find himself set down as the defendant in an action of defamation of character?

Mr. George Meredith, describing in one of his novels a solicitor, says of him, 'A very worthy old gentleman he was, with a remarkable store of anecdotes of his patrons, very discreetly told, for you *never heard a name* from him.' This is the kind of character which every professional man should strive after, be he a medical adviser, a minister of religion, or a lawyer. These professions are largely based upon purely confidential relations, in which open confession to the skilled adviser is good for the body, the mind, and the estate respectively. The fact is that many of the transactions which result from such relations need the fullest disclosure of the patron's secrets; he must reveal his 'business and bosom'. For instance, recall the connotation of the phrase 'family doctor'. It can well be appreciated on this ground alone what an excellent if dangerous source of apposite anecdote the professional relations may be, and in fact are. Hence the golden rule of silence must be observed. To adapt the words of Junius (1770), medical advisers must be 'the sole depository of their patients' secrets, which shall perish with them'. Indeed, it is a com-

mendable and growing custom for medical practitioners to direct, in their last wills, the immediate destruction of all private case-notes unread (see p. 6).

Professional 'Privilege'.

Medical men, as with other professionals, have formed a standard code of etiquette tacitly binding upon themselves, albeit without legal sanction. One of the oldest items of this code is instanced by the proverbial oath of Hippocrates, pledging secrecy with respect to all knowledge gained *quâ* medical man: '*I swear, . . . whatever in connexion with my professional practice, or not in connexion with it, I see and hear in the life of men, which ought not to be spoken of abroad, I will not divulge, affirming that all such facts should be kept secret. While I continue to keep this oath unviolated may I enjoy life and practise my art respected by all men in all times; but should I trespass or violate this oath may the reverse be my lot.*' And although an oath is no longer formally taken (a similar declaration, however, is made by Scots medical graduates), its substance is so emphatically maintained by the profession as a whole that the opinion of Thomas Vicary (1517) still holds: Surgeons 'must be as privie and as secrete as anye confessour, of all thinges that they shal eyther heare or see in the house of their Pacient'. Notwithstanding this pious usage, the only legal penalty run by discussing

the ailments of others is the risk that thereby their characters may be defamed, and the obnoxious action will then become subject to the penal law of the land. Confidences given on extra-medical matters and medical facts observed otherwise than as applied to a patient, e.g. 'testamentary capacity' in a friend, are not under the same rule of postulated professional privilege.

It is generally held that a confidence disclosed to a medical man, as such, continues to be the property of the discloser, and not of the doctor for his own private use. The interest of the patient must be guarded primarily: it is his secret and remains under his control. The privilege really refers rather to the patient than to the medical adviser. The practitioner's duty, it is said, is to avoid, if possible, any imminent physical danger threatening his patient, and he is in no way called upon to disclose his patient's secret. There is, it is maintained by some, a slight difference between the cases where a person voluntarily tells facts to the adviser and where by practical medical examination the latter finds for himself the facts of which the patient is ignorant, though where the difference actually lies it is difficult to see. The proverbial disagreement among doctors may also be an added weight of reason for the implied pledge of secrecy, for your publication, if you break the postulated pledge and disclose a faulty diagnosis you have made, will not have the justification of truth as a plea

in your defence. The privilege existing between doctor and patient is mutual, and the patient discloses the professional proceedings at his peril; he forfeits his privilege. It has been remarked that the main cause of the apparent differences of medical opinion, which is not seldom exhibited in the evidence given in a court of law, is due to statements of the medical witnesses based on facts other than purely medical, and to that extent *nihil ad rem*.

In passing it may be noted how aggravatingly yet advisedly vague the newspapers often are when informing the public that some notable person has had 'an operation' performed on him, or is suffering from 'a serious illness'; a more specific statement might be to their peril. Occasionally the public press reveals clinical facts concerning eminent public personages which had far better have been left unpublished.

It is well to avoid consulting-rooms which are merely screened from waiting-rooms or which are divided therefrom by thin partitions only, for 'walls have ears'. Curious unprofessional friends should not be allowed to remain during a medical examination of a person (as to other precautions in this connexion, see p. 42).

Notwithstanding the implied pledge of secrecy, there are yet many occasions when the confidence of the patient is, as a matter of fact, liable to disclosure with impunity; it is the position of the medical

man who thus publishes confidential communications, which publication would ordinarily be defamatory and punishable, that has now to be considered from the point of view of the law of defamation of character. When and to whom, then, may a medical secret be disclosed, the discloser being innocent of defamation?

There are the cases where a medical man is called in to supersede a prior alleged unsatisfactory practitioner; the former must be careful what he says of his predecessor or his treatment; before expressing any opinion as to the methods adopted by another practitioner the full facts should be ascertained, and they can only be known in most cases by a personal communication with that other. Published accounts of attempted abortion, criminal or 'legitimate', suggest a warning to those who have to remedy or to report upon the previous professional or unprofessional acts of another person.

There may be occasions when clinical facts must be revealed on the principle *se defendendo*; in 1896 a medical man failed in an action against an accident insurance company because he declined to mention the name of the patient who had been the cause of his infection (St. Clair Gray *v.* Northern Accident Insurance Co.). The communications of partners and near relations may also raise practical points for consideration in this connexion.

At the outset it must be confessed that the occasions

and motives, justifiable or otherwise, which lead to the disclosures are very various — so various that a classification of cases based upon such motives may be conveniently made.

The occasions, then, which lead to the publication of the result of professional transactions may be either *private and personal* or *public and forensic*, and the motives prompting such disclosures must be considered separately.

(*a*) The *private or personal motives* which may lead to the exceptional revelation of facts gained by a medical man in his professional capacity are several, and it is premised that for justification in a law court their publication *must be quite innocent of malice*, actual or implied. We may here refer to moral motive, criminal motive, and absence of specific motive. Thus, if the safety of a member of the medical man's own family were endangered by an alliance with one whom he knew as a medical man to be secretly suffering from 'a bad disorder', the great moral pressure which this knowledge would exert upon him would be sufficient ground to justify a disclosure of the state of affairs, but only, of course, after due precautions, to the parties personally affected. The plea of 'necessity' would probably suffice; it might be sufficient to threaten disclosure unless the marriage was postponed until the danger was cured.

Little need be said of criminal motive, as, happily,

examples are all but unknown, and usually appear as a threat to levy blackmail on some knowledge acquired as a professional secret; unfortunately, such cases are not so rare among abortion quacks and their victims. With regard, on the other hand, to the cases characterized by an absence of specific motive, much might be said; they usually occur when thought, instead of preceding, is the tardy sequel of speech. 'Shop' in general conversation should always be avoided; 'shop' which deals with specific persons often becomes little better than garrulous 'gossip', and this the medical man especially must avoid if he wishes to remain respected, whether his practice is in a remote village or in a large township: he should never make his patient the subject of his common conversation; he should, indeed, be ever ready with an evasive or banal reply to such pertinent yet impertinent questions as, 'What's the matter with him, doctor?' or, 'How did it happen?' and, in fact, in all such cases as those in which we were instructed as little boys that 'white lies' were not permissible: you may tell the truth, you may tell nothing but the truth, but you must not in some cases tell the whole truth; or, as has been neatly said, 'you should tell the truth, but be careful *what* truth you tell'. It is, indeed, in these cases that a medical man has to use that judgment with which nature has endowed him; and which—it is to be hoped —will tell him when he should hold his tongue.

Incidentally some minor cautions may be given: do not repeat the statements of the sick or dying—these statements may be subsequently wanted as hearsay, yet valid, evidence in a law court in certain cases (see p. 197); be very loath to express personal opinions on behalf of either side in medico-legal cases pending trial, otherwise you may find yourself subpoenaed as an unwilling witness—this caution is, of course, inapplicable where the statement of claim or of defence has been seen. Always keep under lock and key all letters from or to patients, all notes on actual cases, drawings, photographs, skiagraphs, &c., otherwise you may have to suffer for your presumed carelessness in allowing such matters to be technically published. In hospital and asylum practice, a patient by accepting treatment consents to the implied limited publicity of his case; if he is admitted when unconscious, and remains when he realizes his situation, he is in a similar position. It goes without saying that a medical practitioner in his own private domestic relations may act upon knowledge gained by him at a clinical examination, as in the dismissal of a servant. Medical officers are compelled at times to report unfavourably on the work of subordinates or on the goods supplied by contractors. In doing this, provided they do not exhibit malice, they are safe, as where a District Medical Officer was reported by the Clerk of the Union to a Relieving Officer as being drunk (Sutton *v.* Plumridge,

1848), and where a medical officer reported unfavourably on some wine supplied to a Board of Guardians (Murphy *v.* Kellett).

(*b*) There are occasions when *public or forensic motives* lead or compel a medical adviser to disclose his special knowledge. Such 'discoveries' are sanctioned—if at all—on the all-sufficient ground of public policy, absolutely, i.e. malice does not affect the case, for it must be borne in mind that the practitioner is primarily a citizen and after that a registered qualified medical man, and hence, to some extent, a species of civil servant. In dealing with these public motives for disclosure our tread will not be so firm, as our ground is not so sure as elsewhere; much difference of opinion has been manifested in the discussion of the privileges relative to this part of the subject. The forensic view often cannot be seen from the medical man's standpoint. Jeremy Bentham used to insist that legal officials and public authorities are apt to place civil duties foremost, forgetful that men and women are being dealt with. Where a highly-skilled witness, after gaining full clinical information as to one side of an action, finds he cannot support the claim of that side, it is unwise of him to act for the other side, for he has gained certain private information already which he cannot help using, even unconsciously.

Arguing from analogy with other professions, we find that the communications between a client and

his legal adviser are recognized as being absolutely privileged, and their publication cannot be insisted on even in a court of law. Arguing from various national customs, we find, e. g., in France (*Code Pénal*, art. 378), Germany, and many of the U.S.A. (e. g. New York Code, art. 834), the relations between the medical adviser and advisee are absolutely privileged; in Scotland secrecy is a condition of the contract, and a breach of confidence may be a relevant ground for an action for damages (1851); in New Zealand (Act of 1885) secrecy is enforced in civil cases at least. Arguing from general practice, it is not usual for medical men or medical institutions to act as informers, and hospitals, for instance, have been exemplified as a relic of the ancient idea of sanctuary (although in them the victim is often the party protected), and the sanctity of such institutions and the secrets deposited therein should not, it is said, be violated. The usual practice at hospitals is for the steward to report suspicious cases—as are reported to him!—to the local police. This practice agrees with the high legal opinion recently sought by the Royal College of Physicians of London, but curiously, and certainly unexpectedly, Lord Brampton (Mr. Justice Hawkins) opposed this view, and stated that it would be 'a monstrous cruelty' to report to the Public Prosecutor one such case which he instanced.

The privilege of secrecy obtaining in New York

has been objected to as hindering justice in such practical matters as claims arising from life insurance, injuries the result of malice or neglect, and mental and matrimonial cases. It has been ruled, however, that the medical adviser may testify as to his employment and the number of his visits and clinical examinations, his prescriptions and operations; and if there is an objection raised to a description of them, he may testify as to their value. In 1828 Fournier declined to give evidence in Paris as to a husband's infection with syphilis; his action was upheld on appeal.

The Admissibility of Medical Evidence.

The object of the statutes in the United States of America which make communications by a patient to a medical adviser privileged, unless such privilege is waived by the protected party, has been held 'to save the patient from possible humiliation, not to enable him to win a lawsuit'. In Clifford *v.* Denver and Rio Grande Railroad Company, tried in the Supreme Court of New York in 1907, it was held that where a female patient caused a commission to be issued for the examination of her physician she could not object when the defendant offered the deposition in evidence, for she had waived the statutory privilege. Waiving the privilege at one trial precludes setting it up at re-trial, the better opinion being that where a patient voluntarily has for-

feited the privacy of the testimony the need of the privilege has been demonstrated to be non-existent. The privilege is also lost by the patient presenting evidence of the communication which is ruled incompetent. Similarly, the professional privilege concerning transactions with a legal adviser is waived by making a sworn statement of the communication before a proper authority and publishing it in a newspaper. In the present case the communication was revealed, hence the object of the privilege, the preservation of privacy, could not be attained, and the objection was properly overruled.

Volunteering Information.

In his public capacity a medical man may be called upon either to act as an *informer* or to give evidence as a *witness* in legal proceedings.

Should a medical man act as a volunteer informer? There are those who declare that if a medical man conceals what he discovers and knows to be criminal, he renders himself liable, *ipso facto*, to penalties as an accomplice or an accessory to the crime which has been committed; and, say these folk, cases of murder or infanticide, or attempted suicide, or abortion, or slow poisoning, or the carrying on of an illegal occupation which may come under the medical man's special clinical notice, should be forthwith reported to the Public Prosecutor, otherwise, in Jeremy Bentham's phrase, he

will be *in pari delicto*. There seems to be no definite statement possible, but the tendency seems to point to the fact that, even assuming it is not your recognized duty to see that a criminal is punished when the offence is completed, it is your duty to see that a planned crime of which you have information is not effected; and it is your duty, though you find the facts in question as a medical man, to inform the proper authorities if you learn anything which involves the actual commission of a crime now *in futuro*, or if you are reasonably suspicious of an intended illegal act. The probability is that if you hold your tongue you will come to no harm, for the erstwhile 'misprision of felony' is now obsolete and unknown, and your inaction, being merely passive, could not be construed into aiding and abetting. It may be said indeed that the medical adviser only suspects, he does not know, unless a confession is made; in the latter case it should be referred to a magistrate to take an affidavit if one is desirable. The only definite advice which can be given in addition to this indefinite statement is that you should appeal personally and confidentially to those who administer the internal discipline of the profession—men recognizedly high up—for their opinion as to what course you should adopt in the matter which causes your doubt.

A medical man is, of course, compelled to act as an informer under a penalty in cases where a public

necessity, formulated in an Act of Parliament, declares *salus populi* to be *suprema lex*, notably in the notification to specified public authorities of birth and of certain mental and infectious and industrial diseases; but in the Acts compelling such information only such specific facts and maladies as are enumerated and clearly denominated within their meaning are privileged. Defamatory statements made in the course of proceedings under the Lunacy Act, 1890, are not actionable (1899); the Act specifies in this connexion that there must be no 'reasonable ground for alleging want of faith or reasonable care'. In all these cases the medical adviser is safeguarded by the Public Authorities Protection Act of 1893. In all 'voluntary' notifications the patient must give his express consent.

Turning now from the cases where a medical man may be expected upon public grounds to *volunteer information* he may acquire during his professional work, we come to a final class of cases, including all those bearing on the subject which we have not hitherto mentioned—viz. where the publication of facts otherwise held in confidence is *compulsory*, and as such is *absolutely privileged*, so that not even proof of a special bias in the publication made is sufficient to render the medical man liable to conviction for defamation of character. These are the cases of medical men under examination called as skilled witnesses in legal proceedings (including, of course, those of the

Coroner's court, and it has been decided, in 1905, that this privilege extends to a witness making statements to a solicitor preparing his 'proof'). As Glen has it, 'a communication made bonâ fide upon any subject-matter in which the party communicating has an interest, or in reference to which he has a duty, is privileged, if made to a person having a corresponding interest or duty, although it contain incriminatory matter which without the privilege would be slanderous or actionable.' The word 'privilege' is used in two distinct senses, viz.: (1) the right of the patient to have his secret kept and the moral right of the medical witness to maintain silence, and (2) the freedom from legal liability for statements made on certain occasions. There is an historical background to this matter, which shows that with changing times ideas have also changed.

In 1776, in a case of bigamy, Lord Mansfield held that a physician must reveal to the court what would, if volunteered in private, be considered '*to be guilty of a breach of honour and of great indiscretion*'; in 1823, where a bastard child had been murdered, no privilege of secrecy was allowed, 'but to give that information in a court of justice, which by the law of the land he is bound to do, will never be imputed to him as any indiscretion whatever.' In 1862 it was decided that written communications from patient to doctor describing bodily and mental feelings were *not* admissible as evidence.

The cases in which the discovery of medical documents or information, prepared or obtained by one party to an action, may be objected to upon the ground that such disclosure will be a breach of professional confidence, arise chiefly in connexion with reports by medical men for railway companies and for insurance offices: in the former case, since 1859, it has been held that the claimant cannot call for an inspection of such report unless he was examined in the ordinary routine course after an accident; in the latter case, since 1851, the medical report, if asked for, must be produced (see *Law Times*, 1875, p. 227). It is not generally known that there is a 'clearing house' through which the names of all applicants for £100 or more insurance policy pass for the information of the other offices.

Medical evidence is only excluded on the ground of public policy when subject to certain special rules of law as (1) communications between husband and wife, during coverture, and (2) unnecessary disclosure of matters indecent, offensive to public morality, or injurious to the feelings of third persons.

It is, of course, agreed that the medical witness may absolutely refuse to reply to any question which would in any way incriminate or penalize himself, this being a general rule of evidence with all classes of witnesses. *Nemo tenetur prodere seipsum.*

'It seems quite clear that had the gentleman not attended the trial he would have heard very little if

anything more about the matter, provided, of course, that he had maintained absolute silence as to his patient's affairs in communicating with the other party and with his solicitors, and, further, it is evident that had he gone into the witness-box and declined to answer any questions put to him with regard to her he would have had little or no pressure put upon him by the court to do so. Strictly speaking, the law accords no privilege to the medical man, but in fact, except in cases where grave public interests are at stake, as where the punishment of a crime or the establishment of innocence is involved, it is not very easy to compel a medical man to reveal his patient's secrets in the witness-box. In the first place, unless he or his patient has been indiscreet, it is difficult or impossible to prove that anything relevant to the issue has ever come within the medical man's knowledge; in the second place, the counsel who calls him into the box as a witness on behalf of his client can put no questions to him which savour of cross-examination without the judge's leave to treat him as a hostile witness; and, in the third place, there is a natural tendency to sympathize with his claim of privilege whether it is recognized by the law or not. It must be remembered that if a witness disregards a subpoena and does not come to the court the party who has served him with that document has no very certain remedy. He can sue the witness who refused to obey the subpoena, and may recover from him such damages as he can prove himself to have incurred thereby, but it can be seen that the establishment of such a cause of action and the proof of the resultant damage are not easy matters. The position of the medical man when pressed to give evidence tending to injure a patient is not enviable, but at the same time he can take up a strong defensive position. If his patient has, to use a current expression, 'given away' his medical adviser by talking of what has passed between them, then the position of the

latter is altered by the act of the former, and the obligation of silence may fairly be regarded as to some extent modified' (*The Lancet*, 1908).

'Privilege' of Silence.

Some authorities have asserted that a custom is growing, aided both by judges and by Coroners, of using the medical evidence as a means of indirectly obtaining facts for the ulterior prosecution of the ends of justice. This is not a satisfactory tendency, as it also tends to make the medical man—unconsciously, perhaps—think less of the professional confidence placed in him in other cases. Any attempts to destroy this privilege and responsibility of secrecy should be zealously resisted and the prevalent conditions cautiously guarded, more especially after the amusing, if surprising, *obiter dictum* of Lord Brampton (in the case of Kitson *v.* Playfair), who inquired of Sir John Williams (a special witness) if he, in the event of a case of malpractice (criminal abortion) coming under his notice, would report it to the authorities. The witness said he thought that 'a medical man was obliged to divulge or inform the Public Prosecutor of any crime which had been committed or which was intended to be committed. The higher claim which a man's wife and children had upon him justified him in taking every [necessary] means to protect them.' 'Then,' said the judge, 'all I can say is, that it will

make me very chary in the selection of my medical man.' This was *his* way of expressing the opinion that it is not the duty of a medical man to report to the Public Prosecutor a case of malpractice. In the same case he made another dictum, *obiter*, which, though not the law, was at least a great lawyer's view of the law: a medical man is not bound to give evidence of confidential facts in a court of law, though this, Lord Brampton agreed, would depend upon the judge's personal views, and in any case a committal for contempt of court would be highly improbable if he refused to act as a common skilled witness of facts professionally ascertained (see *Journal of Am. Med. Assn.*, 1907, p. 723).

It is for the judge to decide what questions shall be asked and answered, it has been urged—that is, the medical witness is not the sole judge when he pleads inability to give evidence on account of the professional relationship.

In 1906 Mr. Justice Grantham said to a medical man giving medical evidence in a breach of promise suit: 'I do not know why you were called or why you are giving evidence, but I should have thought that as a medical man you would have acted up to the principles of your profession, which are very well known in this court.'

Dr. Tidy stated that he should advise a medical witness in the above contingency either to hand written evidence directly to the judge, or to refuse

to give evidence, accepting the consequences of his contempt of court, if his inaction in this particular was so deemed to be. Occasionally by observing what is the professional etiquette an action for damages may be lost, as where a medical man declined to nominate the patient who had infected his wounded finger with syphilis (1896). In any case the objection to disclose facts will be allowed as proper even if the medical man is instructed by the Court to consider himself compelled against his own wish.

It would be an advantage if definite rulings, and not mere judicial *obiter dicta*, were available in this matter of 'discretion' (see *Proceedings of General Medical Council*, 1899, p. 199, and counsel's opinion obtained by Royal College of Physicians, 1896).

Before concluding, a few cases which illustrate the application of the statements preceding may be cited. In all instances the patient's interest is the chief concern, but the medical adviser must see to it that none can bring a specious charge of complicity against him.

E. and W. were in partnership. E. had been deceived by his partner as to his share in the concern, and had complained to W. W. requests E. to retire, owing to a charge of immorality alleged (just after E. had complained) by an hysterical and erotic female patient. E., worried about the partnership and outraged by the gross slander, took HCN, having lost mental balance, and died. Here, of course, a law court was the place

in which the sordid tangle of events should have been unravelled—but the knots were otherwise cut (1883).

An 'infant' (under twenty-one) gets into physical trouble, and privately applies to a medical man for assistance. Subsequently he repudiates the account rendered for professional attendance. Can the medical man apply to the parents or guardians for settlement? If he does so he will be in peril of defaming the infant, though it is presumed that the medical advice was a necessary 'within the meaning of the Act', and the infant himself is held liable for any such debt which he may contract. Persons under the control of others should not be treated, if possible, unless the latter know of it.

Mrs. A. sends her servant girl to you and asks you, under cover of a letter enclosing your fee, to examine the bearer and report in writing on her condition. You will comply with this request at your peril: your course is either to return her and the fee, or with consent to examine her and send a letter saying that the only action allowed to the profession is for the patient herself to make a voluntary statement of her condition to her mistress, and that for that purpose you have carefully explained to the girl the facts concerning herself (but see Guy *v.* Green, 1903). It is even unwise to allow a stranger—other than a professional nurse—to be present while you make the examination, unless the patient actually consents to such publicity of the

proceedings—an assistant, however, may be stationed near by.

A medical man issues a report on the present state of health of X., which statement is entered on an official certificate and passes through the hands of a number of people, and X. suffers in consequence; both X. and the medical man know that it will be technically published by the certifier; X. will have no legal or moral right to complain of the facts, for he wittingly lays the facts open to publicity, knowing as he does that the certificate is to some extent a public document (Still *v.* Morris, 1900). This line of argument would apply to a hospital patient who is made the subject of a lecture by one of the staff. The statement of the medical officer as to the quality of the meat supplied by a contractor is not actionable (Humphreys *v.* Stilwell, 1861).

M.D. is called to attend a patient who he strongly suspects is being slowly poisoned, presumably from some criminal motive. What course should he adopt? Baron Martin thought he should inform a near relative of the patient of his suspicions, and if that was of no apparent avail he should lay the facts privately before a magistrate. Professor Christison thought the patient should himself be informed of M.D.'s suspicions. The only alternative and final course which might be adopted appears to be to have the patient removed to a hospital, or ensure that he is placed under trustworthy

nurses; M.D. must then wait for and watch the results of such environment (see p. 193).

From time to time a newly-born infant is found in a garden dead from exposure. The police, hitting on what seems to them a happy idea, issue a circular to all the medical men in the town, suggesting that as a woman lately delivered of a child, unaccompanied with the child, is probably under the care of a local practitioner, they, the police, will be pleased to be put into communication with the mother, via (and this, of course, strictly confidentially) the attending medical man. Medical men must refuse to be caught in this trap, being convinced that, if medical confidences were to be divulged in such a case as this, many lives would be jeopardized, for people would rather suffer to the death than court the publicity which seeking the advice of a medical man might gain them under these conditions. The profession is, after all, not a huge detective agency.

> 'The privilege rather his to stand above
> All threats of law, all "doctrines damnable"
> Of false expediency and social lies,
> Her solitary confidant and friend.'

These instances would not be complete as a series were the well-known case of Kitson *v.* Playfair and wife (1896) omitted. The details would take too long to enumerate. The following is a brief summary:—

The libel complained of was one in which the

defendant, Dr. P., a relative, attributed adultery to Mrs. K., and, as a consequence of the libel, she lost an allowance of £400 a year, which had been voluntarily made to her by her brothers-in-law. Dr. P.'s opinion of her adultery was formed solely upon the result of medical and pathological examination of Mrs. K. while in gratuitous but professional attendance upon her, added to the fact that she had not been in the society of her husband for over a year. The verdict of the jury—that there was 'publication *with interested motive* and *express malice* on the part of Dr. P.', or rather the amount of the damages they awarded, viz. £12,000 (being thirty years' purchase of the lost annuity)—was probably not a little influenced by the fact that Dr. P. formed his opinion and communicated it to his wife, and then at her instigation he informed her brother, solely on the knowledge he had gained confidentially as a doctor, and without giving Mrs. K. any opportunity for explanation—an opportunity for which, in fact, she had pleaded in vain. In this case, as justification was not pleaded, the medical evidence as such counted for little.

The question whether a medical man should reveal professional facts to his wife was not in this case raised nor discussed, and still remains to be adjudicated upon when an appropriate occasion arises.

The following cases would cause anxiety to the medical adviser in whose discretion it lay to make

the facts public: A fog-signalman at work on a railway has an advanced aneurysm; a milk-walker has a specific ulcer on his hand or arm: in these cases it might be well to secure the services of a brother practitioner living in another town, who could approach the directors or the employer in such a tactful way as not to injure the patient's economic position. It may be necessary to certify the medical cause of death of an infant as 'congenital syphilis', the local registrar having declined 'atrophy'; where abortion is suspected in a patient's history it may be possible to trace the operation to its source and prevent the continued nefarious practices of the operator by a judicious intimation to the police. In reporting notes of cases in the professional press, the names, residences, and other unimportant details must be veiled, otherwise the secrets of the patients will be divulged.

What a principal may tell an assistant was discussed in Ensor *v.* Wakefield (1899).

A full discussion, 'Privileged Communications and Professional Secrecy,' will be found in vol. ii of the *Transactions of the Medico-Legal Society* (London).

CHAPTER V

THE LAW OF NEGLIGENCE IN MEDICAL PRACTICE

THERE have been many learned attempts to define Negligence in Law: thus—

'The absence of care according to the circumstances' (Willes J., 1860), and 'The omission to do something which a reasonable man, guided upon those considerations which ordinarily regulate the conduct of human affairs, would do, or doing something which a prudent and reasonable man would not do' (Alderson B., 1856).

The following directions illustrate the application of this section of the Law:—

'Every person who enters a learned profession undertakes to bring to the exercise of it a reasonable degree of care and skill. He does not undertake, if he is an attorney, that at all events you shall win your case; nor does a surgeon undertake that he will perform a cure, nor does he undertake to use the highest possible degree of skill. There may be persons who have higher education and greater advantages than he has; but he undertakes to bring a fair, reasonable, and competent degree of skill' (Tindal C.J., 1835). 'It matters not whether the individual consulted be the President of the College of Physicians or the humblest bone-setter in the village, he ought to bring into the case ordinary skill, care, and diligence' (Garrow B., 1830).

Again,

'Any one who attempts to treat a sick person (otherwise than on sudden emergency) will be liable for any lack of such skill as an ordinary qualified medical practitioner possesses' (Jones *v.* Fay, 1865). John Wilkinson, in *The Office of Coroner* (1618), stated: 'If a man take upon him to be a Phisition or a Surgion, and not allowed to use and practise such faculty, if hee take upon him a cure which dyeth under his hands by his ignorce, it is held to be felony in such phisition or surgion.' 'Any injury to the health, or any death proved to have occurred subsequent to medical, surgical, or obstetrical treatment, is to be imputed to the medical adviser when his procedure has been quite different from what is taught orally and in books by his acknowledged scientific compeers, as the proper treatment *secundum artem* for such a case or one similar to it, and which is universally acknowledged by the medical experience of his compeers to be correct' (Casper). See also Mr. Justice Walton's statement on administering anaesthetics (*Lancet*, April 4, 1908).

Presumption of Correct Treatment.

By the fact of his registration by the State a presumption arises that a qualified medical man has ability in his profession and exercises it duly, and that when in difficulty or doubt he will use judgment; he is not called upon, when challenged, to adduce evidence as to his general skill and fitness. He is held *prima facie* competent in any lawful act, and on the plaintiff lies the onus of proving the contrary; if he poses as an expert or specialist, a higher degree of skill will be presumed: *spondes peritiam*

artis; yet a considerable latitude in the practice of any theory or mode of treatment will be allowed. The Medical Act, 1858, states: 'The name of no person may be removed from the *Register* on the ground of his having adopted or refrained from adopting the practice of any particular theory of medicine or surgery.' But if a jury decide, after hearing all the evidence, that a registered medical practitioner has been guilty of a culpable lack of attention, an absence of due care and caution, or competent degree of skilful knowledge, of wantonness, perversity, or criminal indifference, and on that account has actually caused needless injury and loss to his patient, then the medical man may not only forfeit his professional fee, but, since 1873, he may be liable to an action in the King's Bench Division for damages for the benefit of the patient himself or of his executors and relatives. The malpraxis must be a substantial thing, and will carry responsibility with it for its natural and probable consequences.

The function of the judge in these actions is to state generally what *may be* negligence—that is, to indicate the evidence from which negligence may reasonably be inferred—thus he decides whether the case should go to the jury. For this reason the presumptions of negligence are noteworthy. The jury empanelled for the particular case decides what *is* negligence, and the possibility of contributory negli-

gence is their province unless the judge peremptorily declares *res ipsa loquitur*.

In France, Germany, and Austria, questions as to bad or unskilful treatment by medical practitioners are not submitted to juries, but to medical assessors, and thus publicity is often avoided.

The damages allowed will be compensatory unless aggravation is established; the assessment will vary with the degree of actual and prospective financial loss, and indefinitely for the physical and mental suffering which led to a temporary or permanent loss of enjoyment of life by the injured person. In Scotland the relatives may be awarded a *solatium*.

Omissions and Commissions.

Errors of Clinical Negligence may obviously be of two classes—omissions and commissions. Sir William Jenner used to say, 'More mistakes are made, many more, by not looking than by not knowing.' It was, indeed, sufficient for Sam Weller, an ostler, to plead that he had 'only eyes' to see with, but this plea would to-day be insufficient if made by a registered medical practitioner, for he has many additional modes of looking and of seeing, notably through '-scopes', and these appliances within reason must be applied in aid of diagnosis and treatment. The advice offered to Roderick Random, under examination at Surgeon's Hall, as to the value of giving 'occular demonstration'

is not lightly to be set aside; there are times when a medical adviser must give eyes to the wilfully blind —as, for example, in showing to their lawful owners, through a microscope, any captured smaller beasts of prey, if he diagnoses scabies or pediculosis, and occasionally the exhibition of the minute flora, contained in gonorrhoeal pus or tuberculous phlegm, may have to be exhibited as a *pièce de conviction*. The applications and limitations of skiagraphy must be remembered, and its assistance suggested promptly in suitable cases. An extensive class of errors of omission is illustrated in documents, forms, and certificates which the medical adviser has to deliver: inaccuracy and delay in these matters may be penalized. The entries in death certificates may lead to subsequent annoyance, and even to a Coroner's inquisition, if the whims of the local registrar of deaths are not complied with; the fact of a woman's death within one month of parturition must be stated in the certificate, although the friends of the deceased, for insurance or other policy, may desire that fact to be left ignored, and the practitioner himself may not be unwilling so to do; here also *Nec silet mors*. If, while acting bonâ fide, a mistake is made in filling in a certificate as required by an Act of Parliament, such as a notification of infectious disease, the certifier will be sheltered by the Public Authorities Protection Act, 1893. Another class of case may before long be contested where

unwittingly infected antitoxins or serums are injected with results even more dire than the historic Algerian 'specific' vaccinations produced; the glycerinated calf-lymph supplied by the Local Government Board, although not absolutely warranted, could not lead to forensic trouble if skilfully employed.

It has been felt in some quarters that lately there has been a tendency on the part of High Court judges to place on a somewhat higher plane the care and skill which must be exhibited by a medical practitioner whose professional actions are questioned. This is doubtless a result of registration.

Omissions are the basis of most errors of diagnosis, of treatment they are more commonly commissions. Often, however, the subsequent mistakes depend upon a faulty premiss, which leads to the breach of an established and fundamental Hippocratic principle, *Primum non nocere*—be sure you do the patient no harm! There are many citable cases where heavy damages have been awarded for negligent treatment; if gross negligence is manifested, with fatal results, a charge of manslaughter will have to be met. In 1866 a man, as was his custom, sent two bottles to the chemist; on this occasion one was signed '*Henbane thirty drops at a time*', the other was unlabelled; he wished for Tinct. Hyoscyami and Lin. Aconiti, which, however, were dispensed into the wrong bottles, so that thirty minims of the liniment were taken internally,

a dose which proved fatal. Criminal proceedings against the pharmacist failed, but it was suggested that damages might be recovered, although the unusual practice of sending the phials may have put the dispenser off his guard. In 1903, for misreading a prescription so that an intended single dose of calomel was repeated eleven times by a patient, the dispenser was mulcted in £150 damages. Serious results may have manifested themselves from copying an error, as from the second edition of Ratier's work on pharmacy, published in 1825, where the ℥ sign was printed for the ʒ sign as the dose of Ext. Filicis Liquidum. Technically, one who copies an error adopts that error, and is liable for any resulting injury; so here, copying the prescription made it virtually the dispenser's own: *O si sic omnia!* then, indeed, would originality cease from being the thief of time. Suppose an accoucheur carries puerperal sepsis with him to several successive unsuccessful lyings-in, it will be hazardous for him to continue in his practice unless he takes very especial care, or pauses for an appropriate intermission for 'purification'. Such an instance well exemplifies how quickly, even in one generation of the nation, the cases recognized by the public and by the profession as comprising clinical Negligence may change in character: thus 'hospitalism'—a word coined in 1869 by Sir James Young Simpson in the *Edinburgh Medical Journal*—was a succinct oppro-

brious epithet in pre-Listerian days, to-day it connotes the idea of human perfection in the art and practice of medicine, midwifery, and surgery. Similarly Mr. T. Pridgin Teale has said: 'When I was a student we washed our hands after an operation—now you wash them before.' A Golden Rule of modern surgery is to imagine at each stage of preparation and operation that the proceedings are happening to one's own body.

Apart from a contract or a public duty, that is, unless there is some proof of employment or privity between the parties, a person is not liable for 'a pure omission'. Nowadays, the person injured may have neither recognized nor agreed to remunerate the medical adviser, yet the confidence induced by the close professional relationship is regarded as being sufficient consideration to create a contract and hence a duty. A medical practitioner is not, however, to be held liable for general friendly advice, which, when executed, injures the person advised. It is generally agreed that an unconscious or helpless man can be aided, even surgically, with impunity, whether he be so discovered at first or he has been anaesthetized for a somewhat different purpose, provided such assistance is essential to save his life or to retard his death; if he makes no complaint when he recovers his senses and realizes what has been done, he tacitly assents to the necessary deed. *Volenti non fit iniuria* (see Con-

sent, p. 126). There is no legal obligation, however, to embrace every available opportunity of succouring or of playing the Good Samaritan; one item of A. H. Clough's *New Decalogue* is—

> 'Thou shalt not kill—but needst not strive
> Officiously to keep alive.'

It is undesirable to treat minors and married women without the respective parents', guardian's, or husband's knowledge and consent. Probably a husband cannot prohibit an operation upon herself to which the wife consents—in such cases, however, it is preferable to gain the combined consent.

Personal Responsibility.

Legally each medical practitioner whose name appears in the *Medical Register* is of equal status, and must bear individual responsibility as an independent contractor for his own actions. A registered assistant or *locum tenens* acting for his principal is personally responsible for any Negligence that may be proven in his practice. The matter is more complicated when unqualified assistants—students, nurses, attendants—are considered, particularly where such hold office in large establishments for the care and cure of the sick. If the principal was superintending personally while the alleged act of clinical negligence was committed by the unqualified assistant, then the superior is responsible; but if in his absence the sub-

ordinate omits some precaution in some matter which is within, or in acting goes beyond, the scope of the specific employment, the principal will not be culpable. But every error in the practice of an unqualified person does not imply punishment, as Lord Hale says: 'If a physician or surgeon, even though he is not a regular or licensed one, acting with due care and skill, gives his patient a potion or plaster, intending to do him good, and, contrary to the expectation of such physician or surgeon, it kills him, this is neither murder nor manslaughter, but misadventure. For physic and salves were before licensed physicians and surgeons' (1675). A surgeon must not throw all responsibility for misadventures upon the alleged incompetence of the nurse, for the fact of inefficiency would of itself make it all the more necessary for him to supervise every detail of the operation before, during, and after the event. *Respondeat superior!*

An unsettled point is the liability of the governors of a charitable hospital for the misfeasances of employés. The U.S.A. courts have decided that there is no such liability if a competent staff is employed, and those aggrieved must seek personal redress from the neglectful operator.

Anaesthesia.

No case is on record where an anaesthetist has been challenged in court for administering anaesthetics

with fatal results; liability might arise in such a case from omitting the routine physical examination and preparation, or from quitting the patient when the operation was complete, before the re-establishment of normal respiration. The physical examination should not be left for others to make. If *morbus cordis* is present it will be necessary to explain—to the patient and peradventure to the inquest jury—that anaesthesia was essential if the operation was to be performed, for without such a narcotic state the patient would have died of shock. The regulation that all such deaths are investigated by the Coroner makes the public without the walls of hospitals familiarized with 'accidents' which are happily very unfamiliar within. In 1896 a herbalist at Leeds was acquitted after being charged with causing a girl's death by giving chloroform during the extraction of a tooth (see p. 153).

Two cases of Negligence may be cited in illustration of some of the above points:—

Mr. Hancke requested Mr. Hooper's apprentice to let him blood; he did so from the basilic vein. 'The arm of the plaintiff was greatly hurt, bruised, wounded, swelled, and discoloured, and the plaintiff lost a great, unnecessary, and improper quantity of blood and was sick.' In the consequent action for damages against Mr. Hooper the jury did not think that the injury had resulted from the inexperience or want of knowledge

on the part of the apprentice. Chief Justice Tindal had suggested: 'It might depend on the constitution of the plaintiff,' and further stated: 'A surgeon does not become an actual insurer.' This was in the septic days of 1835, and one is told that venesection not infrequently revealed such peculiar 'constitutions'.

In 1866 Perionowsky was a patient in St. George's Hospital. He was ordered hip-baths as hot as he could bear them; unfortunately, on one occasion, he was scalded. He thereupon sued his surgeon, Mr. Freeman (and Mr. Timothy Holmes, the assistant-surgeon), who had ordered this treatment. The practice in such surgical cases was detailed in evidence by Mr. Curling and Mr. Paget, among others. It was decided that 'The defendants will not be liable for the negligence of nurses, unless they were near enough to be aware of it and to prevent it.' An action would probably have succeeded against the offending nurses, who were not called.

Promising a Cure.

John Perkins, writing in 1642, says: 'If a man contract with a Phisitian, or with a Surgion, that if he should cure such an one, and name him certaine, of such a disease, and name the disease, that he should have ten pounds, the same is a good contract conditionall.' A contract on the terms 'No cure, no pay' is rare, although the parochial medical officer

receives but half the full fee if his patient die within thirty-six hours of the operation—a period of limitation which was set when the effects of shock were more appreciated than were the results of septic infection. Excluding such exceptions, a general practitioner does not, if he is wise, undertake to cure diseases, but to treat his patients; nor does he guarantee to use the highest possible degree of skill; he undertakes the exercise of reasonable knowledge, intelligence, and ability, in faithful attendance, in the selection or retention of independent contractors, and in necessary advice as to precautions to be taken in the future. No absolute liability is recognized. 'Success is nought. Endeavour 's all.' But a medical practitioner must not suddenly and without reasonable notice cease visiting and treating a patient, and he must leave instructions how to proceed when his visits cease.

Surgeons and accoucheurs are perhaps the practitioners most often pursued by litigants with charges of Negligence in doing those things which they ought not to have done. Of physicians—'observers of Nature'—Galen said: 'Medicus curat morbos. Natura sanat'; Gideon Harvey declared more bluntly: 'Physicians amuse their patients while Nature effects the cure.' Certain it is that the heroic policy of 'blood and iron' is beset with dangers unknown to those who practise in matters medical a masterly

inactivity—often, for instance, has the dental surgeon suffered for not extracting '*the* tooth, the *whole* tooth, and nothing *but* the tooth'. It is not an uncommon pleasantry in operating theatres to feign to have forgotten which side of the patient had to be treated. In the U.S.A. a surgeon operated upon the left instead of the right leg, although the latter had been previously prepared; both legs had been injured, and he was convinced that an error had been made in the preparation; he was, however, exculpated by the jury (Sullivan *v.* McGraw, 76 N.W.R. 149).

Need of Explanations to Patients.

A medical adviser is not bound to condescend minutely to explain surgical principles, therapeutics, and prognosis when proposing a definite line of treatment; a general intimation of a likelihood of great pain, danger, or subsequent physical disability is sufficient. Both branches of the faculty have been judicially defended in this particular. 'It would be dreadful if every time an operation was performed an individual was liable to have his practice questioned'; similarly, of physic, Chief Baron Pollock said, in 1859: 'It would be most fatal to the medical profession if no one could administer medicine without a halter round his neck.' There are some very special cases, however, where great care is imperative in explaining the possible result of some suggested source of

treatment, the relation between medical adviser and patient being here somewhat in the nature of *uberrimae fides*; thus due warning as to the possible results should be given in prescribing morphia in alleviation of insomnia, in interfering surgically with the sexual organs, in indefinitely prescribing silver nitrate internally for 'a professional beauty', or when performing a minor operation on the throat of a prima donna. The use of the word 'explore' has been known to frighten timid patients out of the charge of the surgeon who incautiously used it.

Permission to operate.

Treatment does not extend to a surgical operation without special consent; nor may the extent of the operation sanctioned be exceeded unless under very critical conditions. Professional services may not be forced on a protesting patient. From this it follows that if a hospital patient, even when bedded in a surgical ward, declines to follow the surgeon's advice with respect to operative proceedings, he cannot be compelled—he may be expelled. It is not easy to define what strictly is an operation, nor is it clear that it must be performed by a surgeon himself. Technically, if unauthorized it is a 'battery', the preparation and production of the instruments being an 'assault'; thus it appears that vaccination, antitoxin and hypodermic injections, applying mydriatics,

tracheotomy, and catheterization are all in the nature of assaults, and should only be performed after consent has been obtained from the sufferer or from his next friend. If during an operation an unforeseen extension is seen to be inevitable, e. g. the compulsory amputation of the leg when, by mishap, the popliteal artery is damaged during an arthrectomy, proof that such extension was, in the opinion of the surgeon, unavoidable in the interest of the patient's life or health, would be sufficient to exonerate the operator from blame. The case would be different if he had been previously directed by the patient not to perform such an extension.

The medical man has no civil liability if the injury complained of is the result of intervening Negligence contributed by the patient himself or by a third person, such as wilful disobedience to definite instructions; in such cases the medical adviser should break the professional tie at once. Judge Addison is reported as saying: 'You cannot tell people you won't attend any more and that they had better call in another doctor, and then charge for your attendance' (Southwark County Court, April 30, 1901). The criminal law does not, however, recognize the defence of contributory negligence. The question arises in connexion with trials for felonious homicide, for if a man dies 366 days after being attacked, it is presumed that some other cause than the assault

led to his death. It is not allowable to plead either that treatment was refused, or that, but for a surgical operation unskilfully or unsuccessfully performed, the deceased would have survived the 'year and a day' limit. The following cases bear upon the various aspects of this liability: R. *v.* Clark and Blagg (1842); R. *v.* Pym (1846); R. *v.* Kelly (1871); R. *v.* Swindall (1846); Smith *v.* Burns (1899).

Patients or their relatives should be made fully aware of the possible complications both during and after treatment, such as those arising from inherent predisposition, from an anterior or a collateral infection, from mental or nervous influence, and even from remoter effects. The practitioner has continually to bear in mind the difficulties and uncertainties of diagnosis, the imprudence and disobedience of patients, the uncertain degree of carefulness on the part of assistants, the varied views of recognized authorities, and the common fallacy of appealing to isolated instances as precedents.

Malpraxis.

Civil proceedings consequent upon alleged Clinical Negligence are much commoner than criminal, for patients enjoy little satisfaction from knowing that a medical adviser, even if he really deserves it, is paying in person by imprisonment. The more notorious cases are those which lead to prosecutions,

and are what the public generally understand as malpraxis; under such a heading would come gross ignorance or serious neglect of duty in professional care, avaricious treatment for personal gain, the execution of dangerous operations without the consent of the parties concerned, and wilful injury to or destruction of a patient as by an illegal operation—such a fatality might lead to a charge of constructive murder. 'Where the injury is to the person, and the facts disclose fraud, malice, violence, cruelty, or the like, they operate as a punishment for the benefit of the community and as a restraint to the transgressor' (Mayne). In 1733 'the Court resolved that *mala praxis* is a great misdemeanour and offence at common law . . . because it breaks the trust which the party has placed in the physician, tending directly to his destruction'.

The occasions where a medical adviser enters with a *mens rea* or malice aforethought into criminal negotiations may be passed over; the traps into which fall the unwary and unwilling who honestly believe they are doing their duty may be considered. They may come under the head of gross or crass Negligence; as 'going hunting and neglecting patients' (Wills J.); none who exercises his best judgment is a fit subject for indictment. There is no clear distinction from merely actionable Negligence, except in so far as to constitute criminality there

must be such a degree of complete Negligence as the law means by 'felonious'. There are, indeed, two definite operations which are felonies by statute: (1) Inoculation with the virus of variola (Vaccination Act, 1867, s. 32, and Summary Jurisdiction Act, 1879, s. 4); and (2) assisting in an abortion—strictly all attempts at abortion are criminal offences (see p. 143).

Unqualified Practice.

Unqualified practitioners cannot, as can those who are registered, raise in their defence the prima facie presumption that they were skilful and competent, they must commence their defence *ab initio*. The following direction was given in the Indian oculists' case (1893): 'If you think these men deliberately performed these operations with the full knowledge that that which they were doing was useless, unnecessary, and cruel, as the skilled surgeons tell you, you cannot resist the conclusion that the intention they had was to defraud. If you think that this is not established, then they are entitled to be set free.' In 1829 Mr. Archer was treated for a rectal disorder by Martin van Butchell, who was not qualified, although he had had a medical training. Archer died, and the operator was charged with the 'thrusting of a round piece of ivory into and up the fundament and against the rectum of William Archer, thereby

making one perforation, laceration, and wound, &c., in and through the said rectum of the said William Archer'. He was acquitted of manslaughter, Baron Hullock directing, 'If a person, bona fide and honestly exercising his best skill to cure a patient, perform an operation which causes the patient's death, he is not guilty of manslaughter; and it makes no difference whether such person is a regular surgeon or not, nor whether he has had a regular medical education or not.'

In 1807 Mrs. Delacroix was delivered of a boy with the aid of John Williamson, man-midwife, aged seventy-five years; a few days later, mistaking a prolapsus uteri for secundines, his misdirected energy, in an attempt to remove them, led to severe laceration and death. Lord Ellenborough directed that 'he was not indictable for manslaughter, unless he was guilty of criminal misconduct arising either from the grossest ignorance or from the most criminal inattention'; he declared that such proceedings 'tend to encompass a most important and anxious profession with such dangers as would deter reflecting men from entering into it.'

The following case is one of historical interest, it is reported in 2 Wills C. R. 359. The date is 1767, just eleven years after Percivall Pott sustained his compound fracture. S. fractured both bones of his leg; they were set by John Latham, apothecary.

S. called in Stapleton, another apothecary, to remove the bandage; on so doing he declared that the bones were well set and that good callus had formed. For some unstated reason, Thomas Baker, 'first surgeon at St. Bartholomew's Hospital for twenty years', comes upon the clinical scene. The law report says: 'He reads lectures in surgery and anatomy, and is celebrated for his knowledge in his profession, as well as his humanity.' As a matter of fact, he was attached to St. Thomas's Hospital; he was buried at Norwich in 1770. Baker rebroke the bones, saying: 'You must go through the operation of extension', and applied, by way of experiment, 'a heavy steel thing' with teeth, evidently a primitive extension apparatus. This treatment unfortunately did not succeed, and two surgeons of repute gave evidence at the trial that the correct method of straightening crooked limbs was by 'compression', that is, by splints and not by extension. S. gained £500 damages against Baker and Stapleton jointly, the judge declaring that 'he who acts rashly acts ignorantly'.

The following are the classes of cases in which a charge of gross Negligence has been sanctioned: Where recklessness, stupidity, or manifest ignorance in an essential matter has been manifested, or where some wilful injury has been effected, as, for instance, by way of experimentation, or by treatment otherwise than solely for the patient's benefit, or by treatment

when the practitioner was not in a fit condition. It is an established fact that you may not experiment on a patient, not even *in corpore vilo*, or rather that you experiment unsuccessfully at your peril.

A principal is not conjointly liable for his assistants' criminal acts, unless he directs them or co-operates in their execution. A pupil or assistant who has paid a premium could not be discharged for mere intoxication, unless he had imperilled patients by his habits.

Defences.

The defences set up in actions for Clinical Negligence are: (1) the general issue is contested; thus, 'there is no truth in the facts alleged', or no duty was imposed on the defendant; further, even if the facts are true, no negligence can be proved, as the damage, even if not unavoidable, is too remote; (2) there was contributory negligence by which the plaintiff brought the harm on himself or a third person did so by unwarrantable interference.

Consent and Compulsion in Clinical Practice.

Consent is the permission to do a certain act, freely given, without force, fraud, or fear, by a sober and reasonable person, so situated as to be able to form an independent opinion upon the matter consented to (see Undue Influence, p. 189). If a person consent

to an action, later complained of, it will not amount to an assault unless the consent was given through ignorance or fraudulent misrepresentation, or unless the act was attended with a breach of the peace, or was in some other way injurious to the public—as applications of this principle may be instanced physical examinations, personal restraint, and detention. Every person has a right to consent to the infliction of any bodily injury, in the nature of a useful surgical operation, upon himself or upon any child or imbecile under his care. In the case of State children the Board of Guardians must give consent. No one, however, may consent to the infliction upon himself of death, or any injury likely to be fatal (except in the nature of a desirable surgical operation, skilfully performed), or to the infliction upon himself of bodily harm amounting to maim, for any purpose injurious to the public, or to the infliction of bodily harm in such manner as to amount to a breach of the peace. Thus voluntary castration, if not advised medically, would be illegal; similarly, the development of aesthetic plastic operations may lead to legal objections. The proofs of the possibility and of the probability of consent in particular cases lead to wide discussions both in civil and in criminal matters.

There is no legal power to compel a compulsory physical examination and treatment (including surgical

operation). Without the consent, permission, leave and licence of the patient, any action in this direction would be coercion and in the nature of a trespass and an assault. Even where consent is mistakenly obtained as the result of the imagined necessity to submit to authority, it is open to civil and criminal proceedings if assent did not accompany consent. Whatever may be discovered by a physical examination in strict law must be narrated by a medical witness if he is requested so to do in court; there is no recognized privilege of professional confidence, provided the patient before the examination was duly warned of possible consequences (see p. 82).

Object of Examination to be Disclosed.

Every person has a right to know that he may object to a medical examination, and this information should be given him by the authorities in the presence of the medical man called in to examine, who, indeed, should not proceed unless and until he has an affirmative consent, not only to the examination but also to the possible purposes which such inquiry may serve. In the case of prisoners charged with offences under such Acts as the Offences against the Person Act, 1861, and the Criminal Law Amendment Act, 1885, they should be told that they may call, at their own expense, a medical man in their own interest 'in all cases in which the examination seems likely

to furnish evidence as to the prisoner's guilt or innocence'; they should be examined as soon after being taken into custody as possible. Refusal to be medically examined is not to be assumed to corroborate the evidence of the prosecution under the Criminal Law Amendment Act, 1885 (R. *v.* Gray, 1904).

Several cases are on record where a person has consented *malgré lui* for fear of offending an employer or upon sight of a magistrate's alleged order. In 1877 £50 damages were awarded to a girl eighteen years of age, who was charged with concealing the birth of her illegitimate child; she had twice submitted to physical examination under protest on orders, first of the police, and secondly of a magistrate (Annie Agnew *v.* Jobson). In 1881 a servant girl, accused of being pregnant, was examined by a medical man on her employer's order, she merely passively submitting after protest. The evidence was conflicting. It was held that where the facts showed that the plaintiff reluctantly submitted to her mistress's orders, she failed in her action (Latter *v.* Braddel).

A person, except in a few exceptional cases, cannot be compelled to exhibit his person or his injuries in court, although he may volunteer so to do. 'It is a significant fact that not a trace can be found in the decisions of the common law courts of England, either before or since the Revolution, of the exercise

of the power to compel a party to a personal action to submit his person to examination at the instance of the other party' (1891). In the Common Law Procedure Act, 1854, enlarging the powers which the courts had before, and authorizing them, on application of either party, to make an order 'for the inspection by the jury, or by himself, or by his witnesses, of any real or personal property, the inspection of which may be material to the proper determination of the question in dispute', the omission to mention inspection of the person is significant evidence that no such inspection, without consent, was allowed by the law of England. In 1897, when, after a railway collision, a man alleged the dislocation of one of his kidneys, so that it produced 'the secreting of albumen and sugar in the urine', it was held, however, that: 'Urine which has passed from the body is no part of the person. It is a lifeless substance, separated for ever from the individual, and it can be no more indignity to his person, to subject such substance to examination and analysis, than it would be to require a like examination of the cast-off clothing of the same individual.'

Compulsory Examination of the Person.

The chief exceptions to the rule that consent to examination must be given are: (1) under the obsolete Contagious Diseases Acts (from 1864 to 1886 they

compelled prostitutes in fourteen military and naval stations in the United Kingdom to submit to inspection; in 1888 this system was repealed in India); (2) in certain institutions and in the public services examination and operation may be enforced; (3) in the case of prisoners the records of finger-prints and anthropometric details are insisted upon; (4) there are many statutory cases where 'conditional compulsion' applies: the earliest instance is found in the Regulation of Railways Act, 1868 (s. 26): 'Whenever any person injured by an accident on a railway claims compensation on account of the injury, any judge of the court in which proceedings to recover such compensation are taken, or any person who by the consent of the parties or otherwise has power to fix the amount of compensation, may order that the person injured be examined by some duly qualified medical practitioner, named in the order and not being a witness on either side, and may make such order with respect to the costs of such examination as he may think fit.' This form of compulsion has been continued in subsequent Workmen's Compensation and Employers' Liability Acts, both in order to estimate the amount of the original injury and to test from time to time the progress towards recovery, as compensation will cease upon the injured man regaining health—in no case do these Acts give power to insist upon surgical interference in the hope of benefiting an incapacitated

workman. The following are the terms of the regulations as to the duties of medical referees in England and Wales under Schedule I (15) to the Workmen's Compensation Act, 1906: 'If a workman, on being required so to do, refuses to submit himself for examination by a medical referee, to whom the matter has been so referred, or in any way obstructs the same, his right to compensation or to take or prosecute any proceedings under this Act in relation to compensation, or in the case of a workman in respect of a weekly payment, his right to that weekly payment shall be suspended until such examination has taken place.'

An important point has arisen several times out of claims under the Workmen's Compensation Act (1897). An injured workman by that Act must submit himself to a physical examination by a medical practitioner before he can obtain an order for compensation. Now occasionally it happens that the medical examiner, either in his report or in the witness-box, states that a surgical operation or a course of medical treatment in all probability would greatly benefit the injured man and enable him to resume his former or another occupation. In law it is certain that the workman cannot be compelled to submit to that operation or treatment prior to the final assessment of the compensation due to him as the result of the accident. On several occasions, both in court and by arbitrators,

this legal position has been enunciated. Thus, in the Court of Appeal, in a definite case where this question arose, the Master of the Rolls declared that there was nothing in the Act of 1897 which allowed such a compulsion. In July, 1906, however, a very dubious ruling was given in the Southwark County Court, where the judge is reported to have said:—

'I have no power to compel him to undergo the operation, but in order to *induce* him to do so I will reduce his allowance to *a penny* per week; and then if he does undergo the operation, *and if it is unsuccessful*, he can come to me again and apply to have the allowance increased' (see *Law Times*, 1908, p. 398).

In this case there was a very strong probability that the suggested operation would have restored, or at any rate have relieved, the injured man. Several recent decisions in Scotch Courts maintain the right to compel simple surgical operations for restitution of power. In all these operations after accidents there is a risk, be it great or small, that a fatal issue might result, especially in severe operations which have to be performed upon a patient who has been anaesthetized. It is not improbable that if the workman succumbed during the surgical treatment the employer would repudiate all liability for compensation, as it would be alleged that the operation and not the precedent accident was the real cause of death. Hence, whenever at the suggestion of the court an injured workman does

agree voluntarily to undergo an operation, he should always take legal advice and come to a definite, if private, agreement with his employer, so that the latter would be bound to support his family should he die during or after the operation. Apart from a similar previous arrangement, the employer would not be allowed to nominate a surgeon who could demand admission while the operation was being performed, although usually the need for this arrangement would not arise, as the employer would be only too eager himself to pay the surgeon. In this connexion it may be recalled that a man who has feloniously wounded another can plead neither that the victim's death would not have occurred had he placed himself under proper and skilful advice and treatment, nor that had it not been for the unsuccessful line of treatment actually adopted the deceased man would still have been in the land of the living. Another item of interest is that even if a man agrees to allow an unnecessary operation, such a contract cannot in law be enforced, so that the pledged forfeiture of 'a pound of flesh' in Antonio's bond would have been regarded as *pro non scripto* had Shylock attempted to enforce his unconscionable contract in an English court of justice.

Another form of 'conditional compulsion' is in suits for a declaration of nullity of marriage; the court may refuse a hearing if the party will not

submit to a physical examination to test *habilitas ad matrimonium.*

Several further historic instances, which illustrate the principle that the examinee's consent is essential, may be cited.

Mr. Serjeant Ballantine denied the right of the court to order the physical examination of the Claimant.

In the Armstrong abduction case (1885), which led to the passing of the Criminal Law Amendment Act, a medical man of high standing was reprimanded for assisting in a case where a midwife was held by Mr. Justice Lopes to have committed an indecent assault upon a child under the age of sixteen years by examining her upon her consent alone.

With reference to the medical inspection of school children, Sir William Collins asked the President of the Board of Education whether under the Education (Administrative Provisions) Act, 1907, there was any obligation on parents to submit children attending public elementary schools to medical inspection, as well as an obligation upon local education authorities to provide for such medical inspection. Mr. McKenna replied, by written answer: 'In the view of the Board the obligation placed by the Act upon the authority to provide for inspection does not of itself compel a parent to submit his child to inspection' (Aug. 23, 1907).

In August, 1906, the National Society for the Pre-

vention of Cruelty to Children instituted police-court proceedings against the father of a child who was suffering from necrosis of the lower quarter of the left femur. The father declined to allow surgical treatment. It was proved that otherwise the child was well cared for; a general practitioner was called by the Society in order to give evidence of the cruelty by neglect; the case was dismissed by the magistrate.

The position of paupers has been tested in several cases: as to hair-cutting in Forde *v.* Skinner (1830); as to the vaccination of vagrants and poor-law children (Booth *v.* Brindley, 1903, and 3 & 4 Vict. cap. 29, s. 1).

Precautions before Operating.

Precautions which should be observed in connexion with surgical operations may be considered under three questions:—

(*a*) Who is to give consent? It is wise to allow the patient or his friends to suggest the operation, rather than that the medical adviser should insist upon its necessity. If a patient is a child, consent must be obtained from the head of the family or from some one standing *in loco parentis*, thus, from the Poor Law Guardians in the case of children under their control. A surgeon is justified in performing an operation upon a married woman with her consent if he deems it necessary for the prolongation of life,

and the husband has no right to withhold from his wife such surgical assistance as her case requires (Harris *v.* Lee, 1718). In the case of the unconscious, where no friends are accessible, the surgeon must act on his own initiative. Where facts are discovered during the operation which suggest an unforeseen extension, the next friends of the patient should be consulted if possible.

(*b*) How far may the surgeon go after consent has been given? Strictly, there is no right to exercise even a reasonable discretion as to any further operative measures than those originally assented to. A surgeon in Minnesota was given permission to operate upon the right ear of a patient; when the latter was anaesthetized, the left ear was found to be in a worse condition, and was accordingly treated; damages were allowed (Mohr *v.* Williams, 1905). 'The surgeon is the agent of the patient to do a particular thing. He oversteps his authority at his own risk. His action may be right, and usually will be. Yet, after all, it is the patient's body which is being operated upon. The consequence of a mistake or even of a proper operation must fall on him, and no one shall be allowed to decide a question so important and vital to himself, save himself.' Generally, however, a surgeon will be safe in acting upon a fair assumption that the patient would have consented; it is hence wise, after explaining exactly the nature

of the proposed treatment, to secure a general permission to act as best may be determined as the pathological facts are more fully revealed by the operation (Beatty *v.* Cullingworth, 1896). Consent is the permission to do a certain act, freely given, without force, fraud, or threats, by a rational and sober person of sufficient age, so situated as to be able to form an independent opinion upon the matter as to which consent is given. Exemplary damages were awarded in a case (Pratt *v.* Davis, 1905, Illinois) where a woman returned to a hospital under the impression that a minor operation, previously performed, was to be repeated; as a matter of fact, hysterectomy was performed, the surgeon alleging that the operation was for her good, and that she was mentally unfit to be taken into his confidence and to express an opinion on the matter. It was held that: 'Except in cases where the consent of the patient is expressed, or is implied by circumstances and occasions other than a mere general retainer for medical examination and treatment, and except, also, where there is a superior authority that can legally and rightfully dispose of the person of the patient, and who gives consent, a surgeon has no right to violate the person of a patient by a serious major operation or one removing an important part of the body.'

(*c*) How can the surgeon best protect himself from suits for malpractice? For security, a paper should

be filled out in each case, signed by the patient or his next friend and properly witnessed, giving the operator an omnibus authority to do whatever he believes it necessary and proper to do in the particular case. Obviously, this course would often be difficult, if not impossible, to secure, but without it the surgeon is not safe from malice, for if death supervenes, or if the treatment results unsuccessfully, an action may be instituted, as there was possibly no express authority given so to operate. It is not wise to let the patient or his relatives be too sanguine of the results, lest disappointment comes. No mention of 'exploring' should be made, but due warning should be given at the outset if several examinations or repeated operations under anaesthetic may be needed; otherwise the surgeon may be accused of only half-knowing or half-doing his work. All apparatus which has to be worn later should be tested and fitted to the patient before the operation is commenced. The possibility of unfortunate sequelae should be explained before they arise.

The chief lessons to be learned from the well-known case of Beatty *v.* Cullingworth (1896) are:—

(1) It is advisable to have a definite understanding, if possible in writing, as to the scope and the possible results of operative treatment; it is best to have it stated clearly that the matter is left to the operator's discretion to act after gaining full information; more

especially is this the case where a series of operations or examinations under anaesthetics is requisite. It is unwise to offer a too flattering prognosis; having to climb down later may strain the reputation, for to promise another is to compromise oneself.

(2) When a patient is under anaesthetic, apart from the powers of discretion suggested above, and it is seen to be necessary to exceed the extent of the original permission, the nearest relative at hand should be consulted, otherwise the operation should not be enlarged unless the extreme necessity of the case will justify fully the otherwise *ultra vires* action.

(3) It is well to remember that every patient is a possible plaintiff. It is a good plan to note down at once what actually happened in any important examination or operation as soon afterwards as possible.

Consent to make Post-mortem Examinations.

Occasionally disputes arise over post-mortem examinations. Where a death has been reported to the Coroner no autopsy must be made without his official direction. Otherwise the 'lawful custody' referred to in the Anatomy Act, 1832, is possessed by the deceased's executors, whose consent must be obtained prior to any dissection being commenced. Even if a particular manner of embalming, or burial, or crema-

tion, or anatomical dissection has been desired by the deceased and recorded in his last will, his wishes cannot be enforced upon recalcitrant executors—he should have chosen executors in sympathy with his views. If a dissection of the body is made without the consent of the executors, an offence against the Anatomy Act, 1832, is committed. Formerly many paupers were 'unknown', and their bodies were available for dissection; to-day very few are left unclaimed—hence the shortage of 'subjects'. If a patient dies in the middle of a surgical operation, the exploration must not be continued until the death has been reported to and the further examination ordered by the coroner. Organs and specimens cannot legally be retained by an operator, for although there is no property in a dead body, yet it is the duty of the executors to see that it is decently disposed of. Exhumation is only allowed upon the order of the Coroner or of the Home Secretary. If a person dies in a surgery, and a Coroner is informed of the fact, the corpse must not be removed until directions from the Coroner have been received.

In Ballantine *v.* The Employers' Assurance Co. (1893), the insurers demanded an autopsy of the deceased; they applied to the family physician to perform the post-mortem examination; he declined to furnish the report. It was held that the policy must be met as the application had not been made

to the appropriate parties, namely, to the personal representatives of the deceased. In Pollok *v.* Workman (1900) and Conway *v.* Dalziel (1901) damages were claimed by relatives of deceased persons upon whose bodies post-mortem examinations had been made. In Scotland near relatives under these circumstances were held to be entitled to a *solatium*.

CHAPTER VI

SOME DIFFICULT CLINICAL OCCASIONS

(*a*) Spontaneous and Criminal Abortion.

A SPONTANEOUS abortion implies a pathological causation. It may result from an ectopic or a molar pregnancy; from vicious hygiene and the neglect by the woman of rules of health; from an occupational disease or some constitutional disorder, when the so-called 'habitual' abortion may be recurrent. The first of these causations leads inevitably to abortion, which, however, may be delayed and deferred almost indefinitely, that is, it may be 'missed', so that microscopical evidence may be necessary to identify the doubtful uterine ejecta as products of conception. *Deciduoma malignum* is associated with vesicular degeneration of the placenta, and possibly may occasionally follow malpraxis. To these pathological classes of abortion may be appended, as being recognizedly non-criminal in intention, legitimate and therapeutic modes of terminating a dangerous pregnancy.

Spontaneous abortion is rarely discussed in a court of law; occasionally female chastity may be probed by a minute examination of uterine ejecta.

By criminal abortion is implied the artificial interruption of pregnancy with the intention of wilfully destroying the foetus, whose right to life is thus absolutely ignored. If no pathological sequelae result the *corpus delicti* may never come to light, but if a septic and fatal infection results a constructive felonious homicide will have been perpetrated. It is usually the desire of all the parties concerned to keep undisclosed the whole nefarious transaction. As Sir Samuel Garth said:

> 'And how frail nymphs by abortions aim
> To loose a substance—to preserve a name!'

Criminal abortion may be attempted in the early months of pregnancy by general physical violence, including the cruelty of the husband. Later, reputed abortifacient drugs may be ingested, having been procured through a hinting advertisement; it will be for the jury to decide, if a *noxious drug* has been administered. Finally as the other means adopted have failed in effect and the outward and visible sign of *graviditas* is showing itself, as a last resource local manipulation and instrumentation are invoked.

In strict law all attempts to procure abortion in its wider sense are criminal, but in practice it is only unskilled criminal abortions which become public, owing either to the consequential severe illness or to the uncertifiable death which follows.

Attempts to procure abortion during the earlier

months of pregnancy are especially dangerous to the woman, for usually she does not regard her clinical condition as worthy of the necessary precautionary rest; further, the uterine blood-vessels may not be occluded nor the involution of the thinned uterus take a normal course.

A woman with child may treat her obnoxious condition secretly; she may invoke the aid of an accomplice; or an abortionist may be prompted to act by a third party, the victim being ignorant of this felonious design. It is to be noted that if the woman is not in fact pregnant, she cannot, in law, attempt to procure abortion upon herself, nevertheless a stranger cannot plead such an excuse if he ventures the attempt; *quaere*, if the foetus is dead but unexpelled, can the woman be said to be pregnant? If the termination of the wilful abortion is fatal the woman is *felo de se*.

In the other cases a statutory punishment is imposed where it is proved that an abortion has been attempted, and should the victim die as a result, constructive murder will be the charge made against the operator.

Two minor practical points may be queried:—

1. How far, by drug or by a change in the mode of life, can the onset of labour be accelerated or postponed?

2. What is the position, from the standpoint of clinical jurisprudence, of a medical practitioner called in to attend a woman who has been the subject of

an attempt at abortion? It is commonly held that the abortionist but not the victim should be reported to the police in order that his or her future operations may be watched and checked.

When approached to perform such an illegal operation it is well to have some such reply as the following ready: 'I could have recommended you to Dr. So-and-so, but unfortunately he's in gaol now for doing what you want to a woman last year!'

When Abortion is Justifiable.

As a general rule if care is taken to induce labour by artificial means only when the foetus has attained probable viability, then what is known as *premature delivery* is effected. When the gravid uterus is evacuated regardless of the well-being of the foetus, that is, prior to its attaining the possibility of a 'separate existence', *abortion* is effected. If the foetus is born dead, the term *miscarriage* is useful for polite reference.

In law, all methods of accelerating birth, or rather of preventing the normal continuance of pregnancy, are *criminal abortion*—should the foetus survive, however, no further forensic issues are probable, nor are such probable if the abortion is successfully executed, that is, without a morbid or fatal puerperium.

The medical practitioner, prior to, as well as during, the operation of legitimate abortion, must take certain

definite precautions in order to be prepared with a strong defence should his name and fame be attacked in connexion with his professional advice or actions.

I. He must act throughout openly and court reasonable publicity and confidence before proceeding to operate. The written coinciding opinion of a brother practitioner of recognized probity, who has been called into consultation previously should be obtained and retained. Consent to the proposed measures, in writing, should be extracted from the woman's husband, her parents, or her next friend. During the operation, a friend of the family seated at a convenient distance, or preferably a respectable nurse should be present.

Neither 'for love nor for money' must the practitioner be beguiled into performing an illegitimate operation. He must decline to relieve, under anaesthetic, a wedding-ringless young woman of the shame, as yet perhaps unknown to herself. He must not assist a wife in illegally limiting the number of her children. Indeed, if such seductive proposals are made, the proposers should be warned clearly of the felonious character of their desires; they should be summarily dismissed, preferably after the actual words of the penalizing Act have been recited to them slowly and deliberately.

It must always be remembered that in law the intent and expectation is of greater moment than

the extent of this operation, hence (*a*) Great caution will be needed in treating cases of pseudocyesis, monsters and moles, ectopic gestations, and even of ovarian and of fibroid uterine tumours, for until mid-term differential diagnosis of early pregnancy is often impracticable. (*b*) Although it may be necessary to delay active operative measures until the diagnosis is sure, all temporizings with the patient, which may be of a *primâ facie* suspicious appearance, must be rigidly avoided. Should a *placebo* be indicated to appease a woman who wishes 'to bring on the courses', or 'to remove the obstruction', and who as yet presents insufficient signs of pregnancy, the medical adviser must refrain from prescribing 'reputed abortifacients', and will be wise in inditing the recipe in English. Sudden amenorrhoea in nubile women presumes pregnancy. With such cases an examination of 'the chest' should be suggested in order to investigate the possible local secondary signs of pelvic circulatory activity there exhibited; in these cases excessive zeal in local vaginal examination, digital or instrumental, should be repressed, unless the examiner is positive, as a result of other routine investigation, that a patient is not gravid; similarly rash orders for vaginal douching or attempts to dilate the *cervix uteri* must not be thought of in relief of alleged subjective symptoms or in consequence of the allegation that another medical man is said to have diagnosed 'a displacement of the

womb'. In all these cases the unwary practitioner may be entrapped by the scheming patient, who may know she is not pregnant but be desirous of levying blackmail.

In all operations to induce abortion a full fee should be charged in the ordinary way. Should any unforeseen complications arise it would be well to appeal at once for the professional advice of obstetrical specialists well recognized by the public and by the medical profession generally.

II. Before deciding to operate the practitioner must be confident that he has sufficient skill and ability to carry the process to a successful issue; otherwise he had better refer the case to more competent hands, for any mismanagement is likely to be widely published and will bring great discredit upon his own practice, even if it does not lead to an action at law for malpraxis. The technical legal results of failure are very grave; should the patient die after the operation a charge of 'constructive murder' may be brought against the operator; if the child after birth dies, owing to prenatal artificially inflicted injuries, it will have been murdered. In France an action for damages has been successfully laid against the negligent accoucheur at the suit of the injured child.

It may be taken as sound doctrine that medicinal ecbolics and abortifacients only operate, if at all, by putting the woman's life in extreme peril. Hence

such measures should not be adopted by the medical man, who may be charged with 'administering a noxious thing' should he experiment in this sense.

III. The operator must be quite convinced and fully able to withstand a severe cross-examination as to the necessity of an operation which may result in legal proceedings. He must be prepared to establish that his action, as Lord Hale (1675) said, was 'to cure the mother of a disease', or was on behalf of the child's already jeopardized life. The law has regarded abortion rather as an offence against the person of the gravid mother, than as an assault upon the unborn child, who to that extent is subject to *ius vitae necisque* at the will of a skilled obstetrician. If the continuance of the pregnancy would in all probability be fatal to the prospective mother, the law will condone abortion exercised, as it then is, as a therapeutic measure. Such cases are as follows:—

(1) Where the ovuline structures are involved: as with cystic disease of the chorion, acute hydramnios, or with inevitable and missed abortion. When cases appear to present the signs of a threatened or inevitable abortion, as from rupture of the amniotic hydrosphere or separation of the placenta from its uterine site the need for active treatment will vary: in the former case the uterus should evacuate itself, in the latter case the patient must be carefully guarded against excessive loss of blood, it will be unwise to leave her

(if haemorrhage is proceeding) until the foetus is born, but it must be remembered that even after half the placenta has been thus separated a foetus has continued to live and to thrive until term. Once a portion of the placenta becomes detached it never can functionate again.

With a missed abortion, an unexpelled dead foetus or a molar pregnancy, no interference is necessary unless the mother is untowardly affected, as by resulting sepsis. Every particle that leaves the patient *per vaginam* should be kept for the personal inspection of the medical adviser.

(2) Where a general or local morbid condition of the expectant mother renders a termination of the pregnancy essential. (See Supplement to *Brit. Med. Journ.*, March 14, 1908.)

(*a*) Among the general pathological conditions are the varieties of *Toxaemia gravidarum.*

i. *Hyperemesis gravidarum*, where after mid-term the distressing symptoms continue, and the woman is losing ground; leucin and tyrosin found in the urine is a suggestive sign.

ii. *Chorea gravidarum*, with great restlessness, sleeplessness and consequent exhaustion. *Dementia gravidarum* may be a sequel to the *Chorea* or may be a primary disorder; it should be spoken of as 'brain fever'. Malingerers must be guarded against.

iii. *Albuminuria gravidarum*, whether an acute

nephritis or presenting signs of uraemic *Eclampsia* near the normal term, may or may not indicate the need of an artificial interruption of pregnancy.

iv. Wasting diseases generally may be an indication for abortion if the mother's length of life is to be prolonged: hence *advanced cardiac and pulmonary disorders* may justify the induction.

(*b*) The local causes for procuring legitimate abortion are such as prevent a full term foetus being born *per vias naturales*; otherwise consent to Caesarian section may be refused, or such operation may be deemed unadvisable. In these women the previous health-history, both general and obstetrical, is all-important; their previous experiences, if any; the so-called 'habit' of abortion recurrent at a definite period of pregnancy may aid the accoucheur. A physical examination of the woman is also essential, both by a general inspection of her build, and by local, direct and indirect measurements; a glance at the size of the husband's head or hat may assist. The common justification for abortion is malformation of the bony pelvis: it is necessary (apart from operative procedure) where the true conjugate is less than two and a half inches, or where there is some impassable obstruction as a tumour or cicatrization in the passages through which the foetus travels on the way to birth. Severe uterine displacements, rupture of the uterus may also render the speedy termination of the pregnancy necessary.

(*b*) Anaesthesia.

There are certain clinical precautions which should be considered before a patient is put into narcotic sleep; they are not always sufficiently appreciated. Medical practitioners who, as a matter of daily routine, administer general or local anaesthetics to their patients occasionally fail to remember that to the latter the experience is novel and, to the uninformed, of serious importance. Many patients suffer acutely from ignorance as to the exact procedure with and action of the anaesthetic; in their mental distress they illustrate the view: 'Fear is more pain than is the pain it fears.' Before an anaesthetic is administered it would be well confidently to assure each patient in turn that, subject to a complete previous physical examination, the proceedings will not have a fatal issue. There is another point which causes considerable, if silent, anxiety to persons about to be operated upon: they too seldom have a verbal guarantee that they will not be touched by the surgeon's instrument until they have completely lost consciousness; this dread of a premature incision should be removed: no bandage should be cut, nor should the body be disturbed until sensibility has been abolished, otherwise the patient may suffer a mental strain which is as unintentional as unexpected. There can be no doubt that such a painful shock to the system may produce syncope, which really is not due to the anaesthetic at all. A further caution is that

those standing near the patient, who either is being sent to sleep or is awakening, should be very careful so to turn their conversation that, even if the patient heard the remarks made, they would not alarm or hurt his feelings. The after-smart of wounds should not be forgotten in advising patients.

From the time of the introduction of anaesthetics the alleged danger from their abuse with the purpose of facilitating the commission of crime (robbery or rape) has been canvassed. During the debate on the 'Prevention of Offences Bill' in 1851, the introducer, Lord Campbell, said he shared in the general belief that chloroform might be used with very weak persons without their knowledge by holding a handkerchief to their nostrils; this view he abandoned in the course of the discussion. It appears that very few people could be anaesthetized while asleep without being awakened by the process, probably owing to the partial arrest of the respiration; even with the cases where sleep merged into narcotism a very skilful hand would be necessary in administering the vapour.

There have been no authoritative statements as to the mutual responsibility of the administrator of the anaesthetic and of the operator in cases of sudden death occurring in persons sent to sleep for surgical purposes; probably, each case as it arises would have to be dealt with on the particular facts, which would be left with the jury to decide as examples of negligence.

Both administrator and operator are in most cases registered medical practitioners, and to that extent principals, although it is recognized as one of the duties of the latter to select the former and to control the main directions of the operation. The specialist in anaesthetics has gradually evolved, especially in England; such an one would probably be held as primarily responsible and be closely questioned as to any possible negligence on his part, or any unfitness, or as to any misinformation he gave the operator. The period at which the death occurred would also be pertinent—whether just at the commencement, when the fatality may not have been due to the chloroform, but to the want of it in a sufficient quantity to allay sensibility, or later, when it may have been due to an overdose. It is now recognized that chloroform cannot be given with safety unless the anaesthetist devotes to his part of the operation his whole, entire, and undivided attention, and that continuously; he should never fail to be provided with such appliances and drugs as may be required in an emergency as the only means possible of rescuing a patient (see *The Lancet*, April 25, 1903; April 4, 1908).

REPORTED DEATHS UNDER ANAESTHETICS FOR OPERATIONS, 1899–1906.

	1899.	1900.	1901.	1902.	1903.	1904.	1905.	1906.
Males . .	62	81	89	100	94	99	91	113
Females .	35	35	44	48	52	57	64	70
Total . .	97	116	133	148	146	156	155	183[1]

[1] 64 in London.

Another aspect of this matter is the allegations which patients may make upon recovery from narcotic sleep, particularly of occurrences misinterpreted by them during the phase of *Dämmerschlaf*. It is notorious that under the influence of general anaesthetics it is not unknown for patients to experience sexual hallucinations; on that account appropriate precautions should be instituted. Similarly, confessions obtained from drugged persons, whether the poison was administered or was an auto-intoxication with delirium, need very careful scrutiny before they are credited. Among the doubtful instruments of evidence which may be adduced in forensic proceedings are the statements made by a person *non compos mentis* owing to intoxication at the time when the statements were made. In Indian criminal jurisprudence the practice of handing a man a hookah to smoke before questioning him is historical; in 1905, in the State of Illinois, a case in point arose (Burnet *v.* The People). A man, who was stated to have taken three grains of morphine, was found stupefied and, while under the care of a medical man, fell into a state of coma from which he was aroused sufficiently to give answers to a series of leading questions. As a result of this testimony the defendant in the trial was found guilty but, upon appeal, experts were called who affirmed that any replies obtained as alleged were untrustworthy and might be no more than the product of mental sug-

gestions leading to declarations which were neither voluntary nor responsible; the conviction was accordingly quashed. In 1835, when a police constable gave a man alcoholic drink before extracting a confession from him, Mr. Justice Coleridge admitted that in law drunken lips were competent to offer evidence and to make a confession, though, as a matter of fact, it was open to discussion as to whether they were capable of so doing; thus a forensic restriction may be imposed upon the application of the trite yet often true aphorism *in vino veritas*. It may also be urged that a man under the influence of a drug cannot appreciate the nature of an oath, and hence cannot give evidence, nor can he correctly observe or remember the facts occurring in his vicinity so long as his intoxication persists (see pp. 106 and 168).

(*c*) The Determination of Age in the Living.

With persons who were born at a place and at a time when legislation as to the officially recording of births had been passed, there is little or no difficulty in this matter: all that is required is the production of a certificate of birth given at the General Registry Office (6 & 7 Will. IV, c. 87, s. 38), together with evidence of identity. Glanville (1175) relates a case where the matter was settled by the oaths of eight free and lawful men. Henry of Bratton (1219) relates that the judges were to determine the fact upon

inquiry, *ut si fuerit barbatus, statura magnus vel huiusmodi*; if they were not satisfied, the evidence of the mother and other relatives was to be taken, and, if necessary, twelve *legales homines*, relations and strangers both, were to be empanelled for the determination of the age of a would-be minor. *De aetate probanda* was an important process for those heirs who wished to be free from the king's wardship: a writ was issued to the sheriff of the county where the heir was born, and he held an inquest; the appellant had to declare any noteworthy natural phenomena or civil affairs which marked his year of nativity (see *Romeo and Juliet*, Act I, Scene iii). In 1586 a defendant was proved to be a minor from a view of his person, the examination of witnesses, and a reference to the church book (see Booth on *Real Actions*, p. 147).

To what extent can the physiologist afford real evidence, by the ocular demonstration of which a scientifically accurate result may be obtained where a living person's exact age is in dispute? The state of dentition may assist, as Sir Edwin Saunders suggested it should, for the purposes of testing the employment of young children in factories. When this method was applied in the Goswell Road murder (1883) no definite result was arrived at by the dental experts. With horses this ready test is well known: when the age stated was disputed a dealer replied, 'I had it from the mare's own mouth!' The skiagram

may reveal the state of the epiphyses and condyles of the long bones. The presence of secondary sexual characters may be of service. Stow, the chronicler, relates that it was the rude application of such a test as this by a collector of the poll-tax which culminated the discontent and led to the peasants' insurrection of 1381: 'One of the Collectors of the Groats, or Poll Money, coming to the House of Iohn, others say Wat Tiler, in the Town of Dartford in Kent, demanded of the Tiler's Wife, for her Husband, for herself, for her servants, and for their Daughter, a young Maiden, every one of them a Groat, which the Tiler's Wife denied not to pay, saving for her Daughter, who, she said, was a Child, and not to be accounted as a Woman. "That will I soon know," answered the Collector, and, taking the young Maiden dishonestly, turned her up to search whether she were undergrown with Hair or not, for in many Places they had made the like shameful trial. . . .'

To-day the fact of the exact age of a person may be needed, *inter alia*, to discredit false certificates, for registration purposes (marriage, census returns, or death); for exemption from attendance at ordinary or special schools (Elementary Education Acts); for compliance with s. 96 of the Factory and Workshop Act, 1878; for indictments under the Criminal Law Amendment Act, 1885; for proceedings under the Employment of Children Acts, 1893 and 1903, which place the

onus of proving the age of the child on the alleged offender, and for the Prevention of Cruelty to Children Act, 1904; for insurance and superannuation purposes, and notably in the application of the legal presumptions that a child of less than seven years of age is incapable of committing an indictable offence, and can only be punished for so doing if under fourteen years on proof of actual malice. A child under fourteen must be provided with food, clothing, lodging, and medical care by its parents or at their charge; at sixteen it can acquire a parochial settlement. English statutes usually impose the onus of proof upon the defendant; at the common law, in cases of dispute, infancy is presumed. In addition to registrars' certificates of birth, baptismal registers and, as with a case (Higham *v.* Ridgway) in 1808, the receipted entry in an accoucheur's day-book have been produced and admitted as valid evidence of age. There are, however, still many instances where documentary proof is not forthcoming, and where, in consequence, the age has to be estimated: such is the fact with persons born abroad, orphans, homeless wanderers, and old people who were born in Ireland. It is a common experience for skilful clinicians to be able to cultivate the instinct of surmising correctly the age of their patients with a remarkable degree of accuracy; such precision is usually more marked when the facial inspection occurs while the patient is in bed

and unadorned by deceptive peculiarities in the mode of dressing the hair or arranging the clothes. Recent statutes have adopted the principle of the facial diagnosis of age: 'Where a child . . . is alleged . . . to be under any specified age, and the child appears to the Court to be under that age, such child shall for the purposes of this Act be deemed to be under that age unless the contrary is proved.' An affidavit or statutory declaration before a magistrate may be necessary as a warranty (see Board of Education, Form 123 (*a*)). It is wise to record: 'He gave his age as . . .' rather than 'he is . . . years old'. A nice legal point was raised in Iowa as to how far, apart from documentary and hearsay evidence, a person can be said to know his own age (123 Iowa R. 649). It is useful in case of doubt to speak of the 'practical age' and to distinguish the 'apparent', 'supposed', and 'alleged' age of a person.

(*d*) Drunkenness.

When a reply is sought to the inquiry: What conditions constitute drunkenness? similar difficulties are met as when it is desired to fix at what stage of mental derangement lunacy is an effectual forensic plea; each state must be subjected to full clinical tests, the possibility of malingering being remembered continually. The definition of drunkenness will vary with circumstances. Intrinsically, with the pro-

gressive degree of the vice exhibited, from the disorderly hilarity of one who can take good care of himself while performing such acts as have become to him mere mechanical routine, through the stage at which 'his brains' have been 'taken away'—his memory and judgment temporarily being abolished, down to the condition of the man who, trusting in a generous Providence, cannot stand or walk—or even lie. Extrinsically, with moral and social environments, for the standard by which sobriety would be tested in a prohibition village where a drunkard is conspicuous by his presence would be an antithesis to the criterion applied locally in a city slum where the abstainer is conspicuous by his absence—where, as Mr. Justice Day caustically said, 'The quickest way out of Manchester is to get drunk,' and where the inebriate has not far to seek his favourite public-house, which is generally, like the dying Oliver Goldsmith's desired doctor, 'the nearest.'

The tokens of the effects of alcoholic excess upon the two sexes, whether acute or chronic, whether on mind or on body, differ, perhaps, because the actual beverages and the habits of drinking are different among men and among women. In considering a calculus for the state of drunkenness, the measurable quantity of intoxicant imbibed must be correlated strictly with the indefinite individual quality of the physical health of the subject, and especially that

of his bathed brain tissues. In 1885 Lord Bowen affirmed, 'The state of a man's mind is as much a fact as the state of his digestion;' but in 1731, before psycho-physical philosophy was dreamed of, a learned Master of the Rolls (Sir Joseph Jekyll, the promoter of the famous Gin Act of 1736) gave an historic ruling, 'Neither will this Court measure the size of people's understandings or capacities.' It is not uncommon for men to hear with surprise that they have been found drunk after a small dose of 'a strange drink', or even after a usual potation. 'A thimbleful' may bring out a latent insanity.

To several classes of practical men the medico-legal tests of actual drunkenness are especially important:—

1. A publican at his peril on the one hand refuses a sober customer's order, and on the other hand allows a drunken man, including, of course, himself, to be served or even to be on his licensed premises; he and his servants should be able to tell if and when a would-be patron has imbibed not wisely but too well. Many men are 'scandalously overserved with drink', as was Samuel Pepys at Cambridge. Magistrates from time to time comment upon the social benefit which certainly would result from the more frequent application of the penal powers thus committed to them, for the majority of 'drunks' must leave the public-house in an intoxicated condition. The outward signs of drunkenness may be

excited by a sudden entry into the cold atmosphere of the street. In 1618, in Dalton's *Country Justice*, a quaint test is given: 'Where the same Legs which carry a Man into the House cannot bring him out again, it is a sufficient Sign of Drunkenness.' The conductor who admits a drunken passenger into his public conveyance, and the salesman who allows a drunken man to purchase a pistol, are also liable for such a prohibited offence.

2. The police (and certain other public servants) recognize 'drunks' by popular rules of thumb, added frequently to witnessing an unsteady egress from a public-house. *Quieta non movere* is their common practice. Otherwise, as tyros they have been coached sufficiently in a cardinal canon of amateur 'first aid': when in the slightest doubt as to the sobriety of a man they have apprehended, shifting their responsibility, they 'send for a doctor!' Indeed, when dealing with well-known soakers they occasionally refuse to act upon their own impressions. The inspector is left to decide the condition of his own men, who, as in the Army, are either 'drunk' or 'not drunk'.

3. The medical man is the final referee. The police surgeon sees the 'drunk' after some delay, and may be able to certify personally nothing more than 'Recovering from the effects of alcohol'; clinical facts of importance could be collected if such cases were put at once under medical supervision. The doctor applies

scientific tests to the police suspicions. In wisdom he will give the suspect the benefit of a doubt, and tentatively treat his patient as suffering from a serious physical disorder, unless and until its fleeting nature is demonstrated by a speedy recovery. An injury may be masked or complicated by the subsequent dosage of the unfortunate man with 'a stimulant', administered by would-be friends from whom he should have been saved. The logical differentiation of the condition of alcoholic intoxication has become the more difficult as it is increasingly recognized that many forms of mental facility, involving abnormalities in the physiology of responsibility, are directly dependent upon the presence of definite poison in the circulating blood; to that extent such mental aberrations are concomitant incidents of physical disease, for the brain is more than an organ—it is part of an organism. The recent or remote personal and clinical history of 'a drunken, riotous, quarrelsome, or disorderly person' may dissociate him from sufferers afflicted with nervous diseases, such as the stages precedent to mania and febrile delirium (other than *mania a potu*), attacks of hystero-epilepsy and post-epileptic automatism, or *tabes dorsalis* and general paralysis of the insane, *megalomania*. With the unconscious, insensible 'dead drunk', the incautious may confound those comatose from the student's mnemonic group: 'A.E.I.O.U.' (Alcohol, Epilepsy, Injury, Opium, Uraemia) and a few rarer conditions.

In such cases in towns responsibility for decision should be placed on the hospital or infirmary authorities.

'They cannot with their reeling trunks keep pace,
The tongue trips, mind fails, eyes stand full of water,
Noise, hiccough, brawls and quarrels follow after.'

Such is the classical description of a drunken man by the observant Lucretius, B.C. 60.

Omitting the special characteristics of the dipsomaniac with his crises, the chronic inebriate, and the victim of delirium tremens, it may be well to enumerate the common clinical tests applied to the normal 'drunk' in the pre-comatose stage. There is no absolute neuropathological sign which may be relied upon; the drunkard is a bad clinical witness, and although 'the ear interprets to the eye', it is a sound moral policy never seriously to argue with a drunken man. The condition of the accused man's associates may aid the diagnosis. Prejudiced by the police call, the man's general appearance (with slight ptosis), his irritative demeanour, and the odour of his breath, the medical examiner receives from his patient either no reply to his inquiries or a foolish answer to his charge, perhaps an accusing excuse. If garrulous, a fatuous incoherence may mark the drunkard's clipped speech; the one-sided conversation, however, is based mainly on an emphatic denial of his obvious condition—just as the insane proclaims his sanity. The direction of his argument probably will be obscure. He will be the

victim of suspicions and of irresponsible subjective errors—it is stated that the drunken sailor sees 'the sea-serpent.' While effusively welcoming genial advances, the tipsy man will brook no contradiction nor reproach; this is a practical point of management applied by the police, especially when dealing with female inebriates. His *démarche d'ivresse*, swaying movements and strivings to attain some stable support demonstrate muscular incoordination, whether at comparative rest or while attempting to walk; these signs will be accentuated by directing complicated manœuvres such as toeing a chalk-line, picking up a coin, standing on one leg with the eyes closed—then possibly he will explainingly complain of 'a bad ankle'. Care must be taken not to ignore a real and permanent defect in the legs or in the speech or sight of a person accused with drunkenness. In the more advanced comatose stages, he is unable to stir a muscle, not even the thumbs are moved; unless roused by a violent painful sensation, he rests in peace.

More detailed tests of drunkenness in its earlier stages and those which may be produced in court, if necessary, as 'real' evidence, are based upon the shaking hand, the unruly tongue, and the temporarily blotted-out memory. The humoured offender may be directed to sign his name, to record his address and the date, to repeat some 'hard words'; even if this performance does not lead to great wavering, confusion,

and muddle, it will be, at least, in marked contrast to what he writes and speaks normally with steady hand and tongue and a right mind; the writings may be attached to the official medical report as an exhibit. Usually amnesia is marked in those who have deeply dipped their lips into this tributary to the waters of Lethe. The time-sense is obliterated during intoxication, as in other forms of anaesthetization; statements made as to the hour of the night must be accepted with reservation when they come out of a drunken mouth; this fact long has been the basis of a stock jest among comic editors since the days of Barham's 'Look at the Clock'. Upon recovery from intoxication, depositions then made and words then written and produced as evidence may be denied, because forgotten; while drunk the nature of an oath will not be appreciated. Moral: never take a pledge, for good or for ill, from the lips or from the pen of a man 'in liquor'.

'Indeed! Indeed! Repentance oft before
I swore—but, was I sober when I swore?'

It is a well-known fact that when a person is under the influence of an anaesthetic, the period of time so occupied is telescoped and abbreviated into a moment. On recovery there is no recollection of the events of the interval of unconsciousness, nor of the interval itself. Thus, just before nitrous oxide is inhaled a patient may be set counting 'one, two, three'; conscious-

ness may then be lost and a molar tooth extracted without a wince; upon recovery the counting will be resumed—'four, five, six.' Similarly, a few years back, when a penny journal was giving away ten-pound notes, a hospital patient left his ward for a prolonged operation, thinking: 'I wish I could meet that Ten Pounds Man.' Two hours later, upon regaining consciousness, his first thought, albeit erroneous, was: 'I've got the ten pounds!' The drinking of alcohol has a like effect. Where the toxic effect is chronic it is not uncommon for the victim, when conversing, to repeat the same questions and to reiterate the same narratives at inconceivably brief intervals to the same companion—a process quite redundant with a sober listener—during the same conversation; further, recent impressions—names, faces, facts—appear to penetrate little deeper than the sense organs of hearing and of sight, and thus are hardly recollected by the memory. In sporadic drunkenness several practical tests are available consequent upon this amnesia: 'They have stricken me, and I was not hurt; they have beaten me, and I felt it not.' A common excuse for excessive indulgence is in order that a fearful person may 'forget fear' and that a wretched person may 'forget his misery'. If a drunken man is asked the time of night, he will offer in reply the hour at which he began his drinking, and he will express dissenting surprise when his over-patient wife tells him it is long past midnight.

If a drunken man is asked the amount of loose money in his pocket, he will give the sum originally there before he began to drink to excess and to treat his associates; he will disappoint his expectant wife, who may have been waiting for her full housekeeping allowance from his wages. A medical man met a professional friend emerging from an East End London hostelry. It appeared that the latter was treating a child near by. He asked, 'I'm sober, am I not?' 'Just normal. Why?' 'Such a curious thing has just happened. As I came away from the girl the mother said: "Oh, doctor! is there no hope? Must she die?" "No; please God, we'll pull her through. She'll be out and about in a few weeks!" "Oh, doctor! we thought there was no hope, for this is the third visit you've paid this afternoon!"' Needless to say, after each visit he had returned to the hostelry, and while there recollected that he had set out to visit his patient. Certain criminal associations have been explained by men in drink passing through a 'dream-phase', during which they have acted irresponsibly. It is said that the quarrels of Donnybrook were only among the intoxicated, who continued the unsettled disputes, which had been quite forgotten while the parties were sober; probably *vendettas* were similarly aroused.

These symptoms and signs of the drunken state are regrettably unprecise, and savour of descriptive platitudes. Three additional clinical signs are commonly

present—(1) The body temperature registers subnormally; (2) an impaired pupillary light reflex usually may be noted (Hans Gudden); (3) in the 'dream-state' condition the light reflex and the deep reflexes are also greatly lessened (Hans Gudden, 1900, and Kutner, 1904).

(*e*) **Epilepsy.**

Epilepsy, *per se*, is not a form of insanity, in law; the condition may, however, merge with and develop into epileptic dementia or be associated with epileptic amentia—adjectival attributes of a recognizedly insane mental disorder. To simple Epilepsy the Lunacy Laws do not apply—there are no legal powers whereby epileptics can be confined and segregated, either for their own benefit or for the public safety. Many sufferers are relegated by their friends to 'Convalescent Homes' and other institutions; legal provision is made for their education until the age of sixteen years by the Elementary Education (Defective and Epileptic Children) Act, 1899. As with lunacy and drunkenness, malingering is easy, and the public often manifest doubts when a plea is set up in a defence that the accused was the subject of a minor attack of epilepsy when the alleged offence was committed, nor is this scepticism wholly unsatisfactory, for to the lay mind the appearance of the accused may have been normal, and he may have keenly resented the proffered skilled attention.

Advanced cases of epilepsy are accompanied commonly with definite stigmata of degeneration and general signs of degradation, which are often progressive as the fits are repeated. The victims are gloomy and irritable, fickle and mischievous, forgetful and irascible, rapidly changing, however, from grave to gay, from anger to suavity.

In order to prove the plea of mental defect and so to work upon the jury's natural instinct towards mercy, it will be necessary to establish not merely that the accused had a general reputation for epilepsy, but also that at the time in question he was actually under the influence of a nerve-storm.

The main medico-legal feature is the exhibition of phenomena, the result of post-epileptic automatism, which may lead to results which need the plea—in strict English Law the invalid plea—of an irresistible impulse. Thus indecent exposure (as the reflex acts of a desire to relieve an overfull urinary bladder), suicide, kleptomania (associated with a passion for collecting oddments and instinctively secreting them about the person, possibly to serve as buffers during a fit), and chiefly violent acts and outrages which are apparently the outward and visible sign of a previously pent-up uncontrollable impulse now exploding,—all these instances may illustrate automatic acts replacing or following a fit, and in both cases the fit itself may be masked or larval, and hence unnoticed by an

observer. Forgetfulness, amnesia, may follow a fit, and the epileptic may wander far before he wakes up. Automobile drivers might come to grief if so attacked, for the car would increase and not decrease its speed if the controlling hand and foot were removed.

Death in an actual fit is rare, unless from the exhaustion of *status epilepticus* or from incidental accident. When a man is found dead, lying on his face suffocated, either on his bed or in very shallow water, an epileptic fit may be the history; so too he may fall in dangerous manners or places at the onset of a fit. Epileptics should never be allowed to bathe alone. Insurance companies usually recognize the mode of death in these cases as accidental. It has been held that fainting fits are not 'Epileptic or other Fits' within a declaration leading to a life policy of insurance.

Epileptiform convulsions sometimes occur in acute alcoholism. The fatal convulsions of children may be a variety of epileptic fit, but it must be remembered that 'a child has fits as easily as an adult has dreams'.

Jeremy Taylor, in 1655, stated, 'An epileptick son doth often come from an epileptick father.' The plea of passionate, uncontrollable, or irresistible impulse is usually heard when such a brain-storm being invoked forms a defence against a charge of murder, notably so in the case of infanticide at or just after birth. The routine verdict of the inquest jury: 'Suicide during

temporary insanity', is another common instance where this plea is admitted in extenuation of a grave offence. In less serious offences 'kleptomania' affords a well-known example; this method of defence was made notorious by the celebrated action against the wife of Dr. Ramsbotham, the obstetrician, which is recorded in Serjeant Ballantine's 'Experiences'; this condition is said to be associated with inebriety, epilepsy, and early general paralysis, in which conditions the powers of inhibition are in abeyance, and the sufferer simply assists himself to what he then and there fancies. Baron Bramwell, a particularly 'common-sense judge', used to doubt the presence of such a convenient mental condition. He is reported as saying: 'Irresistible impulse—that is, irresistible in the absence of a policeman!' Probably, the consent given by women to ravishers might at times come under the same category, a consent which prevents a subsequent prosecution for rape. Similar impulses affect audiences and crowds which, by suggestion, are easily led to panic or to riot.

(*f*) 'Good Health.'

The question 'What is good health?' has arisen several times in forensic proceedings, usually in insurance matters. Lord Mansfield made the following statements in this connexion: 'The only question on such a warranty is: Was the insured in a reasonably

good state of health and such a life as ought to be insured on common terms', and again, 'A warrant *quâ* a life policy, that the assured is "in health" or "in good health" can never mean that he has not the seeds of disorder: we are all born with the seeds of mortality within us. A man subject to gout is a life capable of being insured if he has no sickness at the time to make it an unequal contract.' In another case it was found by the jury that a man was 'in good health' although suffering from myelitis (Morrison *v.* Muspratt, 1827). In a Public Health prosecution it was said, 'That is injurious to health which makes sick people worse, e. g. an offensive smell' (1880).

There are many statements recorded as to whether insanity or pregnancy in a particular case was to be regarded as a sickness. A recent insurance case from the Australian courts raised a full discussion on this question from the standpoint of the law. In mid-September, 1902, Mrs. K. took out a policy of life insurance from the National Mutual Life Association of Australasia, subject to the condition, among others, that she was 'at present in good health'. The day after she had been accepted by the office she sent for her medical adviser, with the result that on the next day she was examined under an anaesthetic, and an ovarian tumour thereupon was diagnosed. She went at once into a hospital, and in the course of a few days the offence was removed; she died, however, just

twelve days after she was insured, never recovering from the operation. It appeared further, that a year previously she had consulted a medical practitioner, and had been advised as to the need of a surgical operation before the disorder from which she was then suffering could be cured. Upon the widower claiming the insurance-money, the Association repudiated the alleged policy as having been secured as the result of false statements. In the first instance a jury decided in favour of Mr. K. on the facts of the case as adduced in court. A new trial was then moved for and granted; the Court again upheld the policy, for it was ruled that the malady from which the deceased suffered was not one which, apart from the unsuccessful operation, was likely to shorten life. Upon appeal to the High Court, a broader view was enunciated and judgment was given for the defendants on the ground that the phrase 'at present in good health' must be taken to mean that 'the person insured was free from any apparent sensible disease or symptom of disease, and was unconscious of any derangement of the bodily functions by which health can be tested'.

(*g*) 'Hermaphroditism.'

An early description of this condition is found in 1420: 'Of hermofride, that is to seye, that hath the schappe of Man & womman, and othere of wommen that hath scyne withynne here schape that sche ne

may now3t conseyue the seed of man.' Cases of so-called hermaphrodism occasionally give rise to medico-legal considerations of great interest and importance. The social and political status of the person concerned may hang in the unsettled balance of indecision or may be decided in a summary, if not empirical, manner. It may be asked, What is the ultimate test and characteristic of a man and of a woman in the eyes of the law? Is it, as a matter of forensic physiology, the presence of the alternative and distinctive sexual glands? If this is so, what is the logical position in the human scheme of those beings who are either congenitally or artificially sexless? Allowing that a place should be found for those of neither sex, the cases which have been claimed as a combination of both the sexes—that is, the postulated true hermaphrodites—may be left *sub iudice* until an actual case has stood the test of modern pathological research. In obstetrical practice considerable commonsense must be applied in dealing with a newly-born pseud-hermaphrodite. A definite decision as to the real sex must be confidently and judiciously postponed. It is usually wiser to rear such infants, provisionally, as boys, as such they commonly are, both from the prospective chances of matrimony and from the better outlook which males have in matters of employment. From time to time these children and youths should be inspected, and any indicative sign of sex noted, espe-

cially at the age of puberty. It is stated that 'hernia of the ovaries' when examined shows that those organs have a testicular structure. The French Civil Code allows such a child to be registered as 'sex undetermined'; with us, as also under the Prussian Civil Code of 1900, the sex must be set down unequivocally. Should the medical adviser have the temerity to direct, as occasionally happens, that the local registrar of births must return the infant as of indefinite sex, his scientific doubts will be officially ignored, for at Somerset House the child will be entered as a boy, this agreeing with the above clinical advice. It is obvious, and, indeed, within rare clinical experience, that such a bureaucratic regulation leads to an awkward subsequent *dénouement*. As a matter of fact, some three persons apply annually to the Registrar-General inquiring how they may change their mistakenly reported sex. Lord Coke used to state that the law could do anything—except turn a man into a woman; he, however, was referring to a physiological transmutation. The natal clinical error, confirmed by the certificate of birth, may be, and usually is, tardily rectified on the receipt at Somerset House of the applicant's statutory declaration (see 37 & 38 Vict. c. 88, s. 36, for the form), accompanied by a medical certificate as to the correct sex. Indeed, it appears legally that pseud-hermaphrodites cannot of their own accord choose informally which sex they shall adopt

for civil purposes; the fact was settled for them by the original medical opinion. Cases are recorded in which, upon the discovery of the mistake having been made, the victim has demanded immediate castration or has even committed suicide. The subject of hermaphroditism is fully dealt with in Professor Neugebaur's articles in the *British Gynaecological Journal*, 1903. Few suits of nullity of marriage are published in recent law reports, but the test applied in this connexion is the ability to consummate marriage—*habilitas ad matrimonium*. There are no recognized rules as to the registration at Somerset House of double monsters who survive birth and who are not separable by surgical means; there has been one such return recorded within living official memory; the still-born until lately have been, for almost all purposes, counted as 'nothing' in our present system (see p. 219), and are officially all but ignored.

(*h*) Hypnotism.

The British Medical Association Commission reported in 1893 upon the use and abuse of hypnotism as follows (1) Hypnotism is frequently effective in relieving pain and in procuring sleep; (2) dangers may arise from its use; (3) therapeutically, its use should be confined to registered medical practitioners; (4) with female patients, another of the same sex should be present; (5) public exhibitions should be

under legal restriction (see, however, the *British Medical Journal*, Feb. 19, 1895, p. 513). The following cases have been before the courts during recent years, in which the possibilities of hypnotism have been raised: Kingsbury and Crofton *v.* Howard (1898); a case at the Belfast Assizes reported in the *Law Times* (1907, p. 341); when charged with the murder of M. Gouffé, Bompard successfully pleaded hypnotism (Paris, 1888). In Gross's *Criminal Investigation* (1907) the statement is made: 'the question of the working of post-hypnotism is not nearly so interesting as it once appeared to be, as the strength and length of the effect are shown to be very insignificant'; Dr. Gasquet's views a few years back were as follows:—

'Perhaps we shall do best to suspend our judgment and meanwhile to hold that at any rate only a very small proportion of hypnotized subjects lose all power of resistance. It is unfortunate there should be this conflict of opinion concerning the most important practical question of all. . . . At first sight the dangers of hypnotism seem so great that the temptation is to exaggerate them, but further consideration reduces them to human proportions and teaches us they may be controlled.'

The medico-legal relations involved by the practice of hypnotism have several times been discussed in the courts of the United States of America. In The State *v.* Exum it has been decided that the statement by a witness on cross-examination, that she had been thrice hypnotized by the prisoner, is admissible as

affecting the credibility of her evidence. It was not alleged in this case that the witness was actually in the hypnotic state, for then she would have been held to be quite incompetent to offer testimony (Worthington and Co. *v.* Mercer, 96 Ala. 310). What counsel sought to prove was, that she was then and there the subject of post-hypnotic suggestion (50 S.E. Rep. 283, N.C.). It is admitted that proof of such a mental condition must be very difficult; the judge, whose function it is to decide the competency of a witness, would have to consider many pertinent facts. Once, however, the state of post-hypnotic suggestion is established, there can be little doubt that a witness so obsessed should be ruled unable to testify in behalf of the party responsible for that condition. It must be remembered that the possibility of the victim's following out the suggestions irrespective of the actual facts has never been conceded by many investigators, and the possible actions of the victims of *suggestions à longue échéance* are still debated in the Gallic schools of hypnotism: at La Salpêtrière, with its special class of patient, they hold that the educated moral sense is not annulled by a criminal suggestion; at Nancy they have several practical if reprehensible illustrations that when hypnotized the mind does not revolt at a suggestion which leads in its execution to the performance of a misdemeanour or of a crime. The legal aspect of hypnotism is dealt with in the following references: *The Law*

Times, vols. 40 (p. 570), 95 (p. 500), 108 (pp. 236 and 403) and 110 (p. 549); *The Law Journal*, 1895 (p. 292); *The Harvard Law Review*, vol. 18 (p. 627); *The Yale Law Journal*, vol. 11 (p. 173).

(*i*) The Management of Acute Mental Cases.

There are three varieties of insane patients whom a general medical practitioner may be called upon to manage by securing their safe deposit in an institution where they will be beyond his personal responsibility, viz. (1) those found wandering, (2) those who exhibit dangerous mental symptoms in their own homes, (3) the well-to-do insane.

1. Where a man is found wandering, in an insane condition, he is best introduced to a police constable who will conduct him to the police-station and charge him before the inspector (who may call in medical advice), the policeman then takes him to the master of the nearest Poor Law Institution where he must be seen by a justice of the peace within three days, or else discharged and set at liberty.

2. Medical practitioners occasionally have to decide upon some immediate method of dealing with patients who are the victims of dangerous delirium, notably delirium tremens, and, as such, are quite beyond ordinary domestic control and restraint. Since, at present, there is no home for the necessary detention of such 'temporarily insane' persons—as there is in Paris—

admission has to be sought for them either, in large towns, to a local hospital or to the parochial infirmary. Cases arise in hospitals where those in charge are placed in a difficult position: the staff may consider the patient to be too delirious to be retained, or they may consider him not sufficiently *non compos mentis* to be restrained, fearing, in fact, that any duress on their part, medically justifiable perhaps, might result in an action at law against themselves for assault and for false imprisonment. As a matter of fact, the law does not recognize delirium as coming within the scope of the Lunacy Act, it matters not whether the mental derangement is part of an attack of acute alcoholism, acute apical pneumonia, enteric fever, or septicaemia. Indeed it would be impolitic in medical practice to stigmatize as insane those who exhibit what is euphemistically diagnosed as 'brain fever' as a concomitant incident of their physical disease. Dr. Savage advises his pupils, 'Never certify an alcoholic as insane.' The certification of a patient, the subject of toxic delirium, as having been even 'temporarily insane', would lead to lasting resentment against the medical practitioner who rashly advised it—a piece of worldly wisdom which it is well to remember in cases of puerperal delirium and other similar 'mental' cases. In private practice the difficulty of the management of patients of this class is not so great, for the friends of the delirious person will at once agree with and adopt

any precautionary measures which can be confidently recommended. In a public hospital, however, considerable circumspection may be needed when patients become obstreperous. Thus if a patient suffering from pneumonia attempts, in his delirium, to discharge himself through the window he would, of course, be forcibly restrained, but what if at an incipient stage of his madness he insists on discharging himself through the door? In both cases the consequences may be equally, if not as quickly, fatal. When a man suffering from an acute disorder submits to skilled professional treatment, is he not presumed to recognize the appointed medical authorities as placed over him *in loco parentis* and does he not tacitly concur and submit to any reasonable line of treatment which may be adopted for his benefit? If this is the true relation it would justify the coercive duress necessary to prevent a patient from running headlong to wilful death, that is, unless and until a responsible person arrives who is able to appreciate the critical situation and deal with it. No general hospital should be without an isolation safe room ready for the reception of noisy patients, and further, where a patient threatens to work harm upon himself, the responsibility for his safety should at once be shared by demanding the presence or proximity of the police, who will then be officially associated in the solution of a practical medico-legal problem. In the case of patients in

their own homes, the medical man in charge or, less preferably, a relative informs the relieving officer or the overseer of the position of affairs, and thereby makes the official informed responsible for the patient's welfare. The relieving officer proceeds with a parochial attendant to the delirious person's house, and by stratagem or by force removes him into the safe custody of the observation-ward staff. In especially difficult cases the police are instructed, at the request of relatives if possible, to aid the relieving officer in this process of removal; any reasonable coercion or duress exercised is regarded as justifiable on medical grounds. The Local Government Board has issued instructions to medical superintendents to examine medically all those admitted to the observation-wards, both immediately on admission and just prior to discharge, for bruises, &c. If a justice of the peace is available it is wise to secure a reception order for the patient before he is admitted, for what is commonly known as 'the detention order' really gives authority 'to receive, relieve, and detain'. Any outlay made by the Board of Guardians of the poor in treating a person so admitted will be charged to the patient or to his executors, and applied for in due course by the parochial collector of accounts.

Difficulty occasionally arises with obstinate old or sick people in need of nursing who prefer to exist in squalor and destitution rather than accept the hospi-

tality of the parish. Very often this is due to reminiscences of facts told them by their parents years ago concerning parochial institutions. The out-relief may be reduced to a minimum, temporary relief in kind alone being supplied by the relieving officer. So long as they are physically able to resist they must not be removed unless the condition is such that senile dementia is the kindest diagnosis.

3. In the case of the well-to-do insane it is usual to send them forthwith to a private asylum on the certificate of two medical practitioners actually in practice and in no way interested in such asylum.

(*j*) Pregnancy late in Life.

Contrary to many foreign codes the common law of England allows no presumption that a woman—be she a spinster, a wife, or a widow—has passed an age at which she ceases to be able to procreate and bear children. To the physiologist this pure matter of fact, dependent in most cases upon the menstrual climacteric, is a scientific phenomenon which is never 'judicially noted as the invariable course of Nature'. For the purposes of forensic construction a woman, as well as a man, must be treated as capable of procreating children at any period of life after puberty, for the courts make it a boast that they will never deprive a single living person of a possible interest or benefit. Lord Coke, in 1624, stated a case relative to certain

dowers which accrued only if issue was born 'albeit the wife is a hundred years old . . . or the husband at his death was but four or seven years old, so as she had no possibility to have issue by him ; yet seeing the law saith, that if the wife be above the age of nine years at the death of her husband she shall be endowed, and that women in ancient times have had children at that age whereunto no woman doth now attain, the law cannot judge that impossible which by nature was possible. And in my time a woman above three score years old hath had a child—*ideo non definitur in iure.*' Lord Coke would have us refer apparently to Genesis xviii. 11 and 1 Timothy v. 9. In legal practice the question arises to-day in several classes of cases. It may be requested that money shall be paid out of court to those contingently entitled to it in the event of a certain woman not having children, she being already well past the limit of age for childbearing and having experienced the menopause; as a matter of practical convenience the court has gradually recognized the high degree of improbability of issue from such a woman and early last century, in the case of a woman aged sixty-nine years, a trust fund was disbursed, 'the parties entering into sufficient security by recognizance.' Gradually the age allowed has been reduced until it is now allowed at about fifty-four years and lately the pristine security has been dispensed with. This exceptional remission, however, is never allowed

to infringe the inviolable 'rule against perpetuities'. A similar question arose in the old ecclesiastical courts where a husband pleaded sterility in his newly-married but aged wife; he was not granted a decree of nullity of marriage, as it was held that presumably he had taken her *tanquam soror*. Actuaries are faced with this matter in insurances against childbirth and policies taken out by women under fifty years of age. Cases of pseudocyesis are pertinent, as with Joanna Southcote in 1814, who was sixty-four years old when she claimed to be pregnant by supernatural means. Disputes as to legitimacy and supposititious children occasionally occur in connexion with women well past mid-age. To the medical mind it seems *primâ facie* that a medical certificate could, as a rule, summarily settle the fact as to the probable failure of further issue; the legal mind considers the admission of such a practice as well indecent as capable of too wide extension. It may be noted that husband and wife are incompetent as well as non-compellable to give evidence with regard to their having or not having had sexual connexion with each other while cohabiting in matrimony. In 1787 Lord Kenyon, then Master of the Rolls, when asked to declare that a septuagenarian couple were past the age for procreation, declared: 'If this can be done in one case it may in another, and it is a very dangerous experiment, and introductive of the greatest inconvenience to give a latitude to such sort

of conjecture.' He was evidently suggesting that, should medical or other evidence be admitted, the principle could be applied to much younger women, sterilized perhaps for surgical reasons, and also *pro tanto* to men. In matters marital the law will not often inquire beyond *habilitas ad matrimonium*, the practical test of which is mutual ability to consummate marriage.

(*k*) Undue Influence.

The evidence of a medical practitioner may be required occasionally to aid in deciding whether a patient, whose signature he may be requested to witness, was in fact in a fit and proper mental condition when he purported to conclude certain legal obligations. It may be alleged by those who imagine that they suffer, positively or negatively, from such transactions that the acts were done while the person was under some form of civil subjection, or was afflicted by the duress of disease: thus he may have attained a state of physical and mental decrepitude so that he no longer enjoyed 'a sane and perfect memory'; he may have been intoxicated by a drug or by the products of a disease (as in diabetic coma), or he may have been the subject of another's psychical 'suggestion'. Thus certain unconscionable dealings may have arisen which, if substantiated, will be vitiated as being 'fraudulent' from the Equity standpoint. Testa-

mentary and contractual capacity are the common instances of possible 'undue influence' which are contested. Very occasionally a medical practitioner has been charged with having benefited from a practical appreciation of the mental or physical inability of a grateful patient by illicitly abusing that fiduciary knowledge. In the matter of a 'death-bed will', the onus will lie very heavily upon a large beneficiary under such an instrument to maintain its validity: he will have to establish that (i) the testator was mentally free and capable and was not the victim of 'dominion', coercion, or intimidation, so that he might have sighed: 'This is not my wish, but I must do it, for quiet's sake;' (ii) the document was not drawn up solely by the beneficiary and presented to the testator without the latter being able to take other advice. A medical witness when called upon to give an opinion in such cases must have noted the circumstances of the person influenced: the personal relationship of the parties, the age, intelligence, and strength of the testator, the absence of professional advice, the absence of uninterested persons, the time, the expressions of the testator, and the value of the gift (see *Law Times*, 1880, p. 411; Morley *v.* Loughnan, 1893; and Kingsbury *v.* Crofton and Howard, 1898). Voluntary conveyances by sick people in fits of generosity should be similarly scrutinized and remembered: the medical adviser may be asked if in his opinion the giver was capable of

judging for himself and of securing competent and independent advice, whether the giver was beset or overpowered by any paramount or undue influence, or whether he wished later to revoke the gift when such temporary influence had ceased.

The following are cases in which medical men have figured (see the *Revue de Médecine Légale*, Feb., 1908 :)—

Pratt v. *Barker* (1826). The Court refused to set aside a voluntary deed executed by an old and infirm man in favour of a person who had attended him as a surgeon, and who received the dividends of some stock for him, it appearing that the nature and effect of the deed were fully explained to the grantor, by his solicitor, before he executed it, and that no undue influence had been exercised over him.

Dent v. *Bennett* (1838). Lord Cottenham included medical practitioners as among those whose dealings with patients must be watched with great jealousy. An agreement obtained by a surgeon from a deceased patient was set aside, upon the ground that the Court was satisfied that the patient never did agree to or intend to direct what in the alleged agreement he was represented as agreeing to or directing, and that his signature, if genuine, must have been obtained by fraud or under such circumstances as rendered it the duty of a court of Equity to protect the patient and his estate from being prejudiced by it. This relief stood upon a general principle applying to all the

variety of relations in which dominion may be exercised by one person over another.

Gibson v. *Russell* (1843). A deed purporting to be a conveyance by way of sale of real estate from an aged and infirm person to his intimate friend and medical adviser was set aside for fraud, the money apparently paid at the execution of the deed having been provided by the grantor for the purpose, and the transaction having been kept secret from the family and the household of the grantor.

Holmes v. *Howes* (1872). A medical man obtained an agreement for the sale of land from his patient, an aged and infirm man ; the testimony as to the value of the property was very conflicting. The Court, being of opinion that the patient was aware of the nature of the contract into which he was entering, decreed specific performance with costs.

Mitchell v. *Homfray* (1881). Although a gift made to a person standing in a confidential relation to the donor, as by a patient to a physician, may be voidable, yet, if after the confidential relation has ceased to exist, the donor intentionally elects to abide by the gift, and does in fact abide by it, it cannot be impeached after his death, even if it is not proved that the donor was aware that the gift was voidable at his election.

Radcliffe v. *Price* (1902). It has been laid down that the relation of patients and physician is a con-

fidential relationship, and where it exists, as it did in this case, the donor must have had competent and independent advice before a gift can be supported.

(*l*) Poisoning.

Among the most practical points in clinical jurisprudence are the precautions to be observed by medical practitioners when confronted with suspicious circumstances which may, in their opinion, terminate in the Coroner's court or in some superior tribunal, and so necessitate medical evidence. In all such clinical dilemmas the primary duty of a medical adviser is to treat every patient *as a patient*; he must only act as an informer to the police when compelled by dire necessity. In all such cases it is impossible to be too careful, and very difficult to be careful enough. 'There is a rule of life and a consideration that is far higher than professional etiquette — the duty that every right-minded man owes his neighbour—to prevent the destruction of human life in this world.' Inglis, L.J.-C., in R. *v.* Pritchard (1865).

Chronic or slow poisoning (including drugging and alcoholic): 'It is not because we know less, but because we know a great deal more, than our ancestors that the art of secret poisoning seems to be lost' (Dr. Duncan, junr.).

Probably seldom are such attempts fatal where a medical practitioner is in charge of the case. All

possible preventive measures should be adopted before any suspicion is announced; an action for defamation of character may arise if premature action is taken.

The family medical adviser must not be misled by the characteristic suspicions of alcoholic and weak-minded patients. The personalities of the several members of the household should be studied and understood. The poison, as a matter of fact, may be actually administered by a person wholly innocent of the plot. The symptoms may appear during ordinary medical treatment—'a lingering dram' being substituted for or added to the medicine prescribed, so that the medicine may appear to complete what the poison began. Every possibility of a purely accidental origin of the symptoms must be excluded.

Any objection to the suggestion that medical aid should be sought should be noted, as should also any tendency to make light of the patient's symptoms. All anonymous letters (after being dated) and envelopes bearing on the case should be filed.

If convinced, by repeated examination of the patient's food and excreta, by the symptoms exhibited and by the conduct of the suspected person, that the influence of poison is at work, let it be understood by those in charge that you are not satisfied with the progress being made: suggest the possibility of an accidental poisoning. Do not, at present, associate any name as the suspected culprit: suggest a consulta-

tion with a professional colleague. Have the patient placed under the constant care of day and night nurses, who, although being instructed to receive, retain possession of, and administer all medicines sent and to give personally all food, need not be made party to the tentative suspicions. If this line of defence is apparently being circumvented or is practically impossible, have the victim removed to a nursing home or to a hospital.

Your assured suspicions, without mentioning any name, should be told *viva voce* to the relatives of the person being poisoned, to the family solicitor (who already may be acquainted professionally with the contents of a will or other pertinent matters), or to the suspect himself, with an intimation that the police must be informed if the symptoms continue. If this course is futile, the name can be introduced in the information given to these persons, to the patient himself, or finally to the police or to a magistrate. Should the victim die, a medical certificate should be withheld, and the Coroner should be requested to order an expert toxicological examination of the body of the deceased.

(*m*) Threatened or Attempted Suicide.

In the former case—'sign an urgency certificate, so that the patient can be detained in his own house legally. Any step which is taken, which is in good

faith, with the intention of certifying is justified, and is covered by the law' (G. H. Savage).

In the treatment of attempted suicide special care and watchfulness must be exercised to prevent a further and more successful attempt in a determined patient. The case should, if possible, be treated privately at home, and it should be remembered that delirious, melancholic, suicidal, and mentally or physically defective patients are preferably nursed on the ground floor. Such an attempt is a common law misdemeanour only, and hence there is no need to report the facts to the police; a constable cannot arrest the victim without a warrant unless the offence took place under his eyes. If the patient is in a dangerous condition, the police should be advised not to interfere—not even to make a formal arrest; otherwise he may be taken to a hospital or infirmary.

(*n*) The Treatment of Criminals and their Victims.

When those who are known to have been connected, actively or passively, with an indictable offence present themselves for medical advice and treatment, the question arises: Should the police be informed of the facts ascertained? It is said by some that your duty to the State makes it imperative to breathe a word of suspicion into the ears of the authorities; others say your patient is solely a patient, and that it is better not in all cases to be too inquisitive as to how patients

came by their injuries. If, however, a criminal offence is continuing, every means should be taken to cause it to cease. It is imprudent to relieve or assist a known criminal with any unusual secrecy, or later to aid him in escaping merited punishment. If he makes a statement, it is probable that he was not previously warned that what he said might be used against him. If information is given to the police, the medical adviser must refuse to have the patient interfered with by them if his patient's life and health are likely to be injured by such action.

(*o*) Valid Hearsay Testimony by Medical Practitioners.

'You must not tell us what the soldier, or any one else SAID, Sir,' interposed the Judge, 'it's not evidence' (*The Pickwick Papers*).

There are certain medico-legal exceptions to the above general rule which forbids the reception in Courts of Law of hearsay as evidence.

1. The rule is not strictly observed in the Coroner's Court, wherein a somewhat preliminary inquiry, and not a trial with parties, is held.

2. Spontaneous and voluntary exclamations or confessions are sometimes made to medical practitioners (see p. 43).

3. Where the statement in question was part of the proceedings under investigation, the judge may allow

it in evidence since what was said was really part of the conduct, thus:

(*a*) The complaints and natural expressions of a patient as to what he feels: his words aid in deciding the course of treatment. The effects rather than the cause of the injury are narrated in such cases.

(*b*) The natural expressions of a frightened person, who has not had time to concoct a lie: as after personal injuries, indecent assault, or rape (see p. 44).

4. *Dying declarations.* The medical adviser often hears 'the last whisper of life'. It used to be said 'the solemnity of the occasion was tantamount to the solemnity of a declaration on oath, in view of impending death' (see *King John*, v. iv. 7). The judge decides when such a declaration is admissible, but, when no statement as to the declarant's fear of death is made, the jury has to decide whether it was actually present. In Scotland dying declarations are admitted for what they are worth. It was held in 1845 that a Roman Catholic need not have sent for a priest to celebrate 'extreme unction' for his dying declaration to be allowed. The conditions under which such declarations are admitted are (*a*) the prisoner concerning whom the declaration is proposed to be given must be on his trial for the criminal homicide of the deceased declarant; hence it is only available in indictments for murder or manslaughter. (*b*) The declaration must have been made by a person who, if alive, would be a

competent witness against the prisoner. Thus, if made by a child, he must not have been too young to understand the nature of an oath; hence inquiry as to this fact should be made at the time of the declaration. A declaration by a boy of ten years was admitted, but by a four-year-old child was rejected. (*c*) The declaration must have reference to the circumstances of the transactions which resulted in the death of the declarant. (*d*) The prosecution must show that when the declaration was made the declarant was, as far as could be judged, *in articulo mortis* and, at the time, have had and acknowledged a settled hopeless present expectation of death, and that regardless of the medical view; any subsequent revival of the hope of recovery invalidates the declaration. (*e*) The *ipsissima verba* must be quoted.

It is the duty of a medical adviser when treating one mortally wounded to secure a dying declaration or, better, the dying depositions. Great care must be taken not unduly to alarm the patient. A Magistrate should be sent for, and to him an opinion as to the clarity of the deponent's mind should be given. If no such justice of the peace is available, or his arrival is too late, the medical adviser must act, noting the mental state of the declarant. He should write down the exact words of the dying declarant and any prompting questions, prefixing the whole with the formula, 'I . . . believing that death is about to occur, and that recovery is absolutely impossible, make this

statement . . . '. When completed, read over the declaration aloud and, if possible, obtain the declarant's signature, failing this, the signatures of witnesses. The following statements have not been admitted by the judge: 'I am sure I am going to die'; 'I think I shall never get over it'; 'I think myself in great danger'; 'As I am getting worse'; 'I hope you will do what you can for me, for the sake of my family'; 'No hope, at present, of my recovery'; 'I am aware that I am seriously ill'; 'I'm dying! I'm dying!'

In all such cases the medical practitioner should note down at once any words which may later have to be repeated in forensic proceedings.

CHAPTER VII

CASES ARISING IN THE CORONER'S COURT

In describing to an inquest jury the probable cause of death it is necessary to associate such clinical facts as may be known with the appearance of the body both at and after death. Thus, apart from such accidents where death is seen to be due to a mechanical catastrophe, the medical witness should insist on being ordered or allowed to make a post-mortem examination before he can assuredly give correct evidence as to the facts. Even where a death is witnessed, e. g. a running-over case, or a person walking into a river—and in such cases a medical witness, as such, may be thought to be not needed—it is well to recollect Lord Kenyon's plea in the case where a bird was shot without licence—'it might have died of fright!' A post-mortem would have tested this plea. So imperative is it for medical witnesses to demand a post-mortem before giving evidence, that Dr. Lankester, in 1872, said, 'In nine cases out of ten a Coroner's Inquest without a post-mortem examination is a farce.' In the following cases such an examination may be insisted on as imperative, unless the inquest jury is satisfied

with bringing in 'an open verdict'. (1) *Alleged drowning*: otherwise, in the absence of eyewitnesses of the fatality, 'found dead in the water' is the only logical conclusion. (2) *Alleged overlaying of an infant*: otherwise, 'found dead in bed with the parents' should be the verdict. In both (1) and (2) cardio-respiratory diseases, if present, would assist in arriving at the cause of death. (3) *Alleged still-birth*: for although live-birth cannot be proved by a post-mortem examination in the absence of direct eyewitnesses, unless the child has lived for some minutes after birth, the lungs may have functioned freely. (4) Anatomical post-mortem examinations should be performed wherever possible in cases of medico-legal interest; where a charge of clinical negligence or of criminal homicide may be pending an autopsy is now always ordered. Since the Hounslow flogging case (1846) it has been the rule not to allow medical witnesses to perform post-mortem examinations until they have been directed so to do by the Coroner. The need of a thorough examination is instanced (*a*) as to external appearances, by the Eastbourne thrashing case (1860, R. *v.* Hopley), and (*b*) as to internal conditions, by the Hillingdon choking case (1850, meat impacted after a struggle with an assailant). The medical witness should be the first to see the body and the last to give his evidence, that is, after hearing what other witnesses have said.

It is essential for a medical witness to guard against

the fallacies of confusing the relations of *post* and *propter*, of *in spite of* and *because of*, of the 'cause' and the 'effect', and of the incidental and the consequential. In accidental deaths the condition of the deceased's sense-organs should be considered, and the presence of plugs of wool in the ears, eye-glasses, a walking-stick, should be noted.

In cases of suspected poisoning, or of possible bacteriological interest, the medical witness should take full precautions in preserving and producing in court, as exhibits, the organs or fluids implicated; it will then be open to the Coroner to have undertaken their expert examination, should he desire it. In framing their verdict the inquest jury requires information from the medical witness as to the exact nature of the fatal disease, and, in addition, should there have been violence associated, the nature of the injury, the means or the instrument, and the possibility and probability of its criminal or accidental origin.

Vital activities which may have immediately preceded sudden death or have occurred in articulo mortis. (1) *Respiration*: dust, soot, water, froth, or blood may have been inspired into the nostrils, mouth, and trachea. (2) *Deglutition and Peristalsis*: blood or local water (e.g. from a pail) may have been swallowed; food (often insufficiently masticated) may be impacted or in the stomach; vomit or faeces may have been voided; salivation and mucorrhoea may

have been profuse. (3) *Blood-circulation*: the body may lie 'weltering' in the profusion of blood lost, which may have 'spurted' on to walls, furniture, and floor; the heart and great vessels may have pumped themselves empty; there may be a true extravasation of blood into or a hyperaemia of the tissues (a microscope will reveal inflammatory reaction to an irritant; effusion between the dura mater and the skull indicates external violence during life; the age of bruises can and should be approximately determined); the veins may be swollen on the distal side of a ligature; the blood may give spectroscopic signs of poisoning; the blood in the right ventricle may be diluted (in drowning cases). (4) *Neuromuscular*: the limbs may be contracted, the fists clenched, and articles may be clutched, e. g. a weapon, grass, hair, mud ('a drowning man catches at a straw'); cutis anserina may be present; emissio seminis or abortion may have occurred; intussusception may have taken place in the young; the soles of the feet may be soiled by walking after the injury (e. g. with blood or vomit); the eyelids are usually open at death, closed at birth (see p. 218).

(*a*) Suicide.

When inquiring into the circumstances of a sudden or unexpected death, the inquest jury has to determine, under the direction of the Coroner, when, where, and by what means the fatality occurred. An open verdict,

'found dead', is neither satisfactory nor scientific. The mystery, if such is present, should be cleared up by a statement at least as to the probable method of death: natural, accidental (including by misadventure), or homicidal, which latter includes suicidal. The finding of the jury will be an indication as to the direction of further proceedings, if any, possible to the police, who may suggest murder or manslaughter, or to an interested insurance office, who may suggest some wilful disqualification from payment; the friends of deceased will desire the return of an accidental or a natural cause of death; the Press prefers something sensational.

In cases where the cause of death is doubtful the presumption is against Suicide. The ultimate fact of Suicide, however, is required to be proven by a preponderance of evidence only, and this rule is in no way affected by the subsidiary requirement that the defence must by its evidence exclude every other reasonable possibility of accounting for the fatality.

In cases of Suicide the self-injury has usually been inflicted in solitude and often in silence. Considerable inductive skill may be needed logically to relink the patent and latent chain of circumstantial testimony available. The minor premiss must be skipped; the conclusion is drawn from an argument which, as Jeremy Bentham phrased it, is 'made up of inferences'. Such inferences may be pure fallacies, if a clever

specialist in practical criminology has been deliberately at work. Where death supervenes beyond one year and one day after the injuries were inflicted, it is presumed to have resulted from another cause than the original injuries. A close perusal of the stages and the details of notorious trials in which the ablest exponents of the science and art of Medical Jurisprudence were examined and cross-examined in Court, is the best introduction to the unravelling of a similar present-day problem. Notably are the pages of the Central Criminal Court Sessions Papers worthy of study in this connexion.

There are three sets of facts which should be collated by the inquest jury before reasonable certainty as to the casual relations of a solitary sudden or unexpected death can be determined. The *immediate environment* of the living or dead body when first discovered is a matter which usually comes under the trained observation of the detective police. The *personal and private life-history* of the deceased may be known best by his family and by his closest friends alone, but not seldom not even by them, so that the history perishes with the life of a dead man who tells no tales. Lastly, the purely *medical evidence* of the time, place, cause, and method of death, based on a skilful post-mortem examination of the exterior and the interior of the dead body, is often essential; indeed, nowadays, no Coroner would permit an inquest jury to find

a verdict of Murder or Manslaughter against some person, known or unknown, in the absence of a previous exhaustive necropsy. The medical witness may be able to add certain clinical facts if the deceased had previously been his patient. The fact of the mental condition of the deceased is a matter upon which the inquest jury decides.

I. Opinions formed from a view of the *locus quo.* Failing an eyewitness of the fatal deed, the witness who first appeared on the scene, if observant, should best be able to note the details of the immediate environment of the corpse; otherwise there should be no disturbance or alteration of the effect until a skilled observer has noted the pertinent circumstances; where it is possible a triangulation and photographs of the original scene are desirable. Where the victim is still alive, all other precautions must be subordinated to his timely succour; in such cases the exact initial conditions should, however, be mentally marked. In any case, the police should be associated with the case at the earliest possible moment.

It will be noted whether details point to a struggle or fall precedent to death: Is the furniture disarranged? Could screams or the report of fire-arms be heard by neighbours? Were neighbours at home or out when the deed was done? Has the corpse been moved, robbed, or mutilated? The position of the body and its attitude should be sketched, care being

taken not to be deceived by alterations fraudulently made subsequent to the death. When the door of the room is found to be locked, the presence and position of the key or bolt must be observed—is the window-frame fastened? Is gas still escaping, or is the tap turned on, the 'penny-in-the-slot' meter having exhausted its measured supply? Has there been an attempt to prevent ventilation by sealing outlets and crevices?

The presence or absence of a weapon, a glass or a bottle or a paper which still contains or may have held a poisonous drug, must be noted, as must its relative position to the corpse—it may have been deposited there after the deed in order to mislead inquiries. Such exhibits must be put into safe keeping at once.

All impressions and blood-marks must be closely scrutinized and their nature recorded: on the weapon, on the walls, on the ground; as footprints, handprints, or fingerprints; on the soles of the feet or boots of the dead person or of careless walkers. Is the blood dry? Has any attempt been made to remove the traces of such signs? Is it probably human?

Is there any technical clue available? This may be suggested by the ownership of the weapon, the mode of cutting or stabbing, the method and substance of the ligature (sailors, fishermen, surgeons, butchers, weavers); the material or drug used for any one of

these items may indicate the offender or assist in identifying the victim.

Is there any obvious accidental local cause for the injury: a prominent nail, or a sharp edge struck, a conflagration or an unusual excavation? Has such been utilized with a view to diverting suspicion?

Have the injuries been exaggerated *post mortem*? Are the injuries sufficient to explain death?

II. *The history of the deceased and the personality and private life* may not be known to the medical witness, unless he has been regarded as the 'family doctor'. Great caution must be exercised in theorizing over imputed motives in these cases. The home circumstances may have to be revealed, but all names mentioned in letters left by the deceased should be suppressed. Was there friction, nagging, financial strain, or inebriety? Had self-destruction ever been threatened? Have other members of the family or have recently reported suicides slain themselves by similar methods? Was any physical or mental derangement known to be present? Were sight and hearing good, was he subject to fits, was his occupation dangerous and had he been sufficiently warned? The age of the victim may be suggestive. Can a reasonable or unreasonable motive be suggested: revenge, injury to another's reputation, aversion of suspicion, impotence, chronic disease, avoidance of disgrace such as arrest or bankruptcy, or mere notoriety? Was the

deceased taking a drug which in large doses taken in error as to quantity or method may lead to death by misadventure? Have a will and contracts been recently made or an unused return ticket taken? Are there any writings, entries in a diary, or appointments cancelled which may bear upon the unexpected death? Is there any ground for presuming a 'temporary unsoundness of mind'? When actually in Court it may be well to glance round and note if any person is evidently watchful of, interested in, or distressed by the proceedings.

III. *The medical evidence* may aid in solving the problem. Medical aid may arrive in time to catch the last whisper or sign of life; the former should be at once recorded, as the words may under these circumstances afford a valuable piece of evidence, being a Dying Declaration (see p. 198).

The medical eye will note exactly in which hand and how the weapon is held, and the condition of both; the situation and character of all the injuries, including those which may have been inflicted on the hands of the deceased; whether the exposed and 'popular' parts have been chosen for injury; the position or arrangement of the eyelids and the limbs; the distribution of the marks of blood or chemical stains or hair-fibres on the body and clothing which may be indicative of a struggle or of the fact that the victim was erect or was recumbent when the injury was

being inflicted. The absence of mark or injury from certain parts of the body may be noteworthy.

A few pertinent generalizations in the matter of suicide are possible :—

Although a suicide may strive to slay himself by alternative methods in rapid succession, he will not inflict upon himself such grievous bodily injury as a would-be murderer would upon him—women are loath to disfigure their persons, even in death. Before attempting suicide what are hastily thought to be obstructions are usually removed: the throat is uncovered before it is cut, and the chest uncovered before it is shot at or stabbed ; the bonnet and shawl will be left on the canal bank : probably this partial undressing is an automatic action. If all the clothing has been divested, an accident is the presumption with men whose death is found to be due to suffocation in the water.

In the case of multiple suicides, and murder previous to suicide, it will fall to the medical witness to advise as to the probable priority of death among the deceased.

Unsuccessful attempts at Suicide are dealt with on page 195. A man may have died from an injury self-inflicted or self-sought, but not intended to have resulted fatally, e. g. self-performed tracheotomy or blood-letting, or in order to secure compensation or accident insurance money. Historical examples may be cited where a

victim of murder has been so placed as to appear self-slain, indeed several public scandals designedly have been suddenly silenced in this way; there are other notorious cases where the reverse policy has been practised. In such cases it is very important to be able to determine the real medical cause of death.

(*b*) Unexpected Deaths.

Where a patient dies suddenly and unexpectedly from a cause which obviously is not the one under treatment—as when anaesthetized or after an operation—it is wise to visit the friends of the deceased at once on hearing of the fatality, and to enumerate to them the possible explanations of the issue. Affirm, if possible, that there is no reason to have expected or suspected any one of them, and that all the precautions usual in such cases had been foreseen and taken. Report the death to the Coroner, or advise, where such a report is considered unnecessary, that a post-mortem examination should be conducted for the satisfaction of all the parties concerned. Somewhat similar steps may be necessary when a medical adviser is accused of having passively neglected or actually maltreated a deceased patient, or where he has had in his practice a series of clinical accidents and ill-luck.

(*c*) Suffocation of Infants in Bed.

Dr. Wolveridge, in his *Speculum matricis* (1671), states: 'Many, through the intemperancy of their

nurses, who, by drinking, to increase their milk (and perhaps make it bad enough) sleep so securely and profoundly that they overlay their nurseries in the night, and the children [are found] dead by their sides in the morning.' This is still the popular view as to the cause of 'overlying', but, admitting that the abolition of cradles from the homes of the poor is the root cause, two other facts have lately been brought into prominence: (1) many of the children found dead in bed were suffering from broncho-pneumonia; (2) the mothers were quite as often dead-tired as dead-drunk on retiring to bed.

The hour at which the mother went to bed, and her condition then, should be inquired into; also whether any other of her children have suffered a similar fate. The time when the child was found dead must be extracted, as also the time when it was last suckled.

The external signs of suffocation are a congested face, with froth, sometimes blood-stained, at the mouth and nostrils (this sign may have been removed), limbs flexed and hands clenched; the nails may be blue, and bright punctiform haemorrhages may be noted on the conjunctiva and eyelids—which latter will be open. There may be pressure-marks either from compression by the weight of the parent or by pressure on the bed; in other cases a slow asphyxiation has occurred under the bed-clothes. A dissection will show the engorged right heart and lungs, the

brain-vessels will be full of blood, there may be minute haemorrhages in the trachea, and elsewhere the blood remains fluid. If there is any disease of the lungs the presence of hypostatic congestion after death, or oedema produced by the stagnation of the circulation just before death, must not be overlooked.

The best form of stating the cause of death in these cases is: 'Suffocation under the bed-clothes from the absence of fresh air.' It is noteworthy that most cases occur with children before they have been weaned, and particularly with children under four months of age. Where cots or cradles are still used this cause of death is very rare indeed.

A very noteworthy section in the *Criminal Statistics for the Year 1902* was a summary of the opinions of certain of the Coroners most likely to be cognizant of cases of 'Children suffocated in Bed'. Under this heading several general conclusions were arrived at. There is considerable agreement that in connexion with these deaths foul play is rare, whereas accidents are common; that drunken mothers helpless under the weight of alcoholic drink are less at fault than parents 'dead-tired from excessive overwork, especially on Saturday night', when often a heavy meal is taken just before retiring to rest; and that in the better social classes such lamentable accidents are veiled by being certified as the result of 'convulsions'. Those who have any experience of the Coroners' courts in

which the evidence afforded by post-mortem examinations is welcomed, have been struck by the large number of infants who, having died suddenly in bed, exhibit upon examination a pathological condition of the organs of respiration. These tiny victims have been suffering usually from broncho-pneumonia, and a little difficulty in obtaining a supply of fresh air has stifled their feeble vitality, just as men with bronchitis or morbus cordis are much more quickly asphyxiated by drowning than are healthy persons. It may be recalled that Ben-hadad was sick when Hazael murdered him by placing the wet coverlet over his mouth and nose. There can be no doubt that in this particular a reversion to the habits of our grandmothers is eminently desirable; medical practitioners, certified midwives, social workers and district visitors in our more crowded cities should insist upon their charges adopting the practice of placing tiny children in a cot or cradle at night. The chief objection which has to be met in this connexion is that it is cruel to separate the baby from its mother—indeed the contention that the child would perish with cold has been put forward not unfrequently. Among the very poor the little extra expense entailed in providing separate accommodation, cot and clothing, has been alleged as a consideration. This, however, is but a specious obstacle, for, as Coroners (who so often and so wisely use their courts as adult schools) advise when they

meet with these accidents: 'An orange-box makes an excellent cradle.' A few years ago the writer saw at one of the lodges of Hawarden Castle a banana-crate fulfilling this very useful function.

(*d*) Infanticide at Birth.

A child is live-born, in the legal sense, when, after entire birth, it exhibits a clear sign of independent vitality—in practice, at least the evanescently persisting activity of the heart. Positive proof of the alleged live-birth of a given now-lifeless child is necessary in law. Where respiration was never fully established, in the large majority of cases, it is essential for one present at the act of parturition to give direct evidence, as well of the complete birth as the subsequent exhibition of a sign of life. The medical witness can usually give little more than circumstantial evidence. After several days of life the reliable vital tokens notable by a skilled eye are manifold. The arched chest and the conditions of the inflated lungs and the diaphragm; the empty ductus arteriosus and the impervious vessels of the withered cord; the contents of the digestive tract, and, more indirectly, the condition of the layette and the skin, may all indicate a brief survival after birth when actual movements and cries were unwitnessed by a third person. But should the foetus die while being secretly introduced to the world, or should the child succumb immediately

after such introduction, great difficulty arises in efficiently proving its live-birth. By post-mortem examination alone it is almost impossible to furnish skilled evidence of a fleeting post-natal life—a vital admission early extracted from the medical witness by those interested in the defence of the accused. The child may have lived and moved and had its separate being, but, in the absence of any eye- or ear-witness, though the chain of circumstantial testimony of live-birth may be lengthy, the forging of the links will be weak. The foetus may have been born macerated or it may speedily decompose; 'a hidden untimely birth' may obviously have been unable to sustain a separate existence. The body when dissected may display no abnormality or casual mortal sign: on the other hand, marks of violence may be exhibited, extensive in distribution or in degree, with accompanying extravasations of the circulating blood. 'No one flogs a dead horse', and such signs are scarcely compatible with post-mortem infliction: children may be mutilated, where they 'are come to the birth and there is not strength to bring forth', usually in such cases by a recognized accoucheur; they may be hidden owing to injuries sustained during a difficult labour, the mother fearing a suspicion of wilful injury. The moulding of the head, which records the voyage of the infant, the site and contamination of injuries, the length of the birth-cord, and even local fingerprints,

may be suggestive. The birth-cord may have been snapped or cut and possibly tied; it may have been twisted round the child's neck, and, as in one case reported, include a foreign body in its grip. The association between the bloodlessness of the child and the activity of the heart is very noteworthy; such a test of live-birth is usually supported by signs of active inspiration. Foetal blood (with some nucleated red corpuscles) may have trickled from a wound and collected in a pool, as where, with a severed birth-cord, the respiration has been obstructed, or it may have been jetted over the child or elsewhere. Air may have been inspired into the circulatory system. The vaginal contents, meconium, water, or local ashes, may have been inhaled or swallowed during suffocation. 'The floating of the lungs' test was called years ago 'that hydrostatic humbug'.

If a child is known to be still-born it is not a subject for an inquiry by an inquest jury: two definitions of the condition have been recently—and for the first time—officially sanctioned. The Central Midwives Board, with the approval of the English Branch of the General Medical Council and of the Privy Council, have defined, 'A child is deemed to be still-born when, after being completely born, it has not breathed or shown any sign of life.' The Notification of Births Act, 1907, necessitates, in places where the Act is adopted, the record of still-births also, which includes

every foetus of more than five months' gestation. Unless it is certain that the child was still-born, an inquest will be held upon its body to ascertain the probable facts of the case. The verdict may influence bastardy proceedings and insurance claims. If the child is proved to have lived 'for a few gasps' merely, it will be entered as dying aged one minute, a fact which will necessitate its registration of birth and death, and hence it must be named; further, the burial must be that of an ordinary deceased human body. In law 'newly-born' signifies, less than twenty-four hours old.

(*e*) Certified Midwives' Cases.

The Midwives Act, 1902, gave the Central Midwives Board power to regulate the practice of certified midwives. Apart from registered medical women, of whom there are now nearly one thousand, after 1910, only such women whose names are to be found on the Midwives' Roll will be allowed to practise midwifery for gain, and they may only undertake 'normal cases of labour'. 'In all cases of abortion, of illness of the patient or child, or of any abnormality occurring during pregnancy, labour, or lying-in, a midwife must explain that the case is one in which the attendance of a registered medical practitioner is required, and must hand to the husband or the nearest relative or friend present the form of sending for medical

help, properly filled up and signed by her, in order that this may be immediately forwarded to the medical practitioner. If for any reason the services of a registered medical practitioner be not available, the midwife must, if the case be one of emergency, remain with the patient and do her best for her until the registered medical practitioner arrives or until the emergency is over. 'After having complied with the rule as to the summoning of medical assistance, the midwife will not incur any legal liability by remaining on duty and doing her best for her patient.' If the medical advice arrives after the patient has died, the death should be reported to the Coroner, and the action of the midwife under the above rule will be inquired into; usually the Inspector of Midwives under the Local Supervising Authority will be present. Medical practitioners should discover from whom they can claim their fees when called in aid by a midwife, in cases where the patient is unable to pay personally; usually it is from the Poor Law Guardians.

(*f*) Deaths from Inanition.

There are several pathological conditions which, from a cursory external view of the body, give similar appearances to those found in cases of death from slow starvation whether by misadventure or by culpable neglect. A full post-mortem examination will be necessary to differentiate these conditions.

1. In Starvation.—The coats of the intestines are translucent, atrophic, and contracted. The liver and kidneys are small, and no putrefaction-gas will be evolved from the former organ. The ammonia co-efficient is high and may represent two-thirds of the total nitrogen eliminated.

2. Stricture or compression of the oesophagus.

3. Various forms of malignant disease, including certain diseases of the blood.

4. Addison's disease.

5. Hysteria, Anorexia nervosa, Insanity, Pernicious vomiting of pregnancy; these are really varieties of 1.

6. Dysentery, Sprue, and chronic diarrhoea.

7. Tuberculous diseases: pulmonary, intestinal, or meningitic. In possible meningitis the arachnoid bodies must not be mistaken for tubercles.

8. Diabetes. The history of polyuria; the thickening of intestinal mucous membrane; the normal or enlarged liver and kidneys, the normal heart; the contents of the urine—all differentiate this disease from Starvation. Sugar and acetone may be present in some others of the above conditions. Diabetes is occasionally associated with sudden death.

CHAPTER VIII

SOME LIMITATIONS OF MEDICAL EVIDENCE

THE science, the art, and the correct estimation of the value of medical evidence is the province of Forensic Medicine. It is not impertinent, therefore, to inquire as to what limitations can be and are placed upon the medical witness who desires to bear testimony in a court of law as to facts within his personal knowledge. Evidence, it may be said, is the means whereby an alleged matter of fact, the truth of which is being submitted to forensic investigation, is established or disproved. Testimony is such evidence as is given by word of mouth. Usually medical practitioners are skilled common witnesses of fact; often they are asked for opinions inferred from such facts as they narrate or may have narrated to them. In offering any consequential testimony they must recollect that they are posing, perhaps unconsciously, as experts; they would be wise in many instances in just stating what was actually seen, without drawing a possible or probable conclusion. In such a case John Hunter in 1781 twice told the judge: 'I can give nothing definite.'

Limitations of medical evidence may arise in two directions—limitations of current medical knowledge and limitations imposed by the policy of the law. The former restrictions become fewer with the advance of time, research, and medical education—for men's views narrow with the progress of the 'scopes'. Limitations imposed by rules of law are enlarged less easily; indeed, modern statutes are notorious for the strictness of their definitions—a strictness which often makes it difficult to bring home wrong-doing to a real culprit's door. All definition implies limitation. Cases are on record where well-known physiological facts have been ignored in order to follow an earlier legal precedent. In this connexion it has been said that in Forensic Medicine, the Law leads and Medicine follows, whereas in State Medicine, Medicine leads and the Law follows.

Limitations of medical knowledge may be relative to the medical witness concerned—and may then be self-imposed or enforced—or they may be absolute. Thus the diligence, skill, and knowledge of medical practitioners vary from age to age and from person to person. So variable is this range that a patient is expected to be treated only to the best of his particular medical adviser's ability, and not in the best manner possible by an authority on such matters. Recognizing personal limitations, it is wise for all

professional persons to be on their guard, and to risk no disgrace, when in doubt, by a delay in applying to a superior authority at once, be it a senior or better informed man or, in the medical profession, to a clinical research laboratory. Never, however, must what another investigator has found or proved be given as first-hand evidence in a court of law. It is a presumption of the law that all 'qualified medical practitioners' are competent professional advisers; this to some extent explains the attitude of the public to the differences of medical men of varying standing, to medical dilemmas and dubious diagnoses. Medical witnesses should be continually mindful of the fact that counsel will probe what they have omitted to do. An authority, so-called expert, will be less likely to quail before such questionings, but there are some matters in which the only expert, or at least the most expert, is the prisoner standing in the dock; thus, such a person with malice aforethought may have confused, fictitiously and factitiously, the differential signs usually indicative of murder, suicide, or accidental death. Our medical forefathers, innocent alike of analytical chemistry and of morbid anatomy, were safe in the witness-box only because counsel were, if possible, still more ignorant. Sir Robert Christison, in 1857, was made to withdraw an emphatic statement as to the tastelessness of white arsenic, when a junior counsel confronted him with a posthumous

edition of Orfila's treatise on Poisons. In studying the older records which bear upon legal medicine many annoying omissions are met with. The depositions, in the State Trials, concerning the birth of a son of King James II's wife are not full enough to tell us if he was born alive or born dead; in other words, whether the Old Pretender was supposititious or not (1688). The records of the sudden death of Sir Edmund Bury Godfrey still leave it a subject for discussion whether he was murdered or slew himself (1678). The facts related of Elizabeth Canning are not sufficient to elucidate the mystery of her disappearance (1752). The occurrence in the inquest jury's verdict, in former times after a view of the body, of the words *Morbus caducus* is far too frequent to be pathologically definite. Such vagueness, at a later date, led Dr. Farr to advise Coroners to be more precise in recording the verdicts of the inquest juries (1842, Fourth Report).

Certain facts of common knowledge are supposed to be admitted in court as 'being in the ordinary course of Nature', or as being within the judge's memory. An obsolescent limitation to medical evidence may arise, however, from the incredulity of the Bench, as when, in 1857, Lord Chief Justice Cockburn discredited the testimony offered from microscopic signs: 'in admitting the advantages of science, they were coming to great niceties indeed when they speculated upon

things almost beyond perception, and he would advise the jury not to convict on this scientific speculation alone.' At times a similar incredulity as to newly-ascertained facts has been exhibited when specialists have given evidence before Royal Commissions—an example being the alleged rate at which railway trains would run. Baron Bramwell once said: 'A judge is not bound to know the ingredients which constitute peroxide of iron.' The origin of Paris and Fonblanque's treatise on Forensic Medicine is to be traced to the fact that when Lord Chancellor Eldon asked Sir Samuel Romilly the difference between 'soda' and 'subcarbonate of soda,' no one present in court could tell him.

Another relative limitation arises when some restriction is imposed upon the medical witness while, wittingly or unwittingly, he is really qualifying to give his evidence. Thus, when a full physical examination of a person cannot be obtained, or when consent to conduct an autopsy is withheld, there are several matters which, under the circumstances, will remain obscure, which otherwise might be made patent. Never must such unrevealed matters be made the subject of guess-work. To-day this form of limitation is made less noteworthy, as a full physical examination is gradually becoming customary: this applies both to clinical and to post-mortem work (see p. 42). As to cases where complete post-mortem examinations are essential, see p. 201.

The second variety of limitation, owing to the lack of sufficient medical knowledge, is not relative to the medical witness personally, but is a general inability to make a positive declaration owing to the uncertainty, insufficiency, or inconclusiveness of the facts available. Even recognized authorities in this variety of limitation may have to confess that they do not know certain facts, or will, when pressed, offer a very guarded opinion. Thus, in questions of prognosis the commendable attitude may be illustrated by an aphorism of Dr. Samuel Gee: 'There is only one thing certain in giving a prognosis in phthisis—that is, that you will certainly be wrong.' Further, in questions of malingering the very elect may be nonplussed, as is illustrated in Dr. Weir Mitchell's fiction, *The Autobiography of a Quack*. The physicians of the early eighteenth century would have difficulty in discovering the ground of Clarissa Harlowe's lover's pretended haemoptysis—of fowl's blood! A few definite instances of such limitation, due to unavoidable ignorance, are as follows: (1) The exact age of a living man, woman, child, or infant cannot be determined apart from witnesses or a birth certificate. 'Expectancy of life' is mostly the clever conjecture of actuaries. The age of a skeleton, after complete ossification, is guesswork. The sex of a very old or of a very young person's skeleton cannot be affirmed. (2) In the absence of foetal heart sounds, pregnancy cannot be

affirmed until quickening has been felt by an observer or until the foetal parts are palpable. Affiliation to a putative parent on account of an alleged personal resemblance is insufficient (see *Edinburgh Medical Journal*, April, 1906). Chastity cannot be impugned from an inspection of the hymen. (3) The presence of gonorrhoea cannot be established by microscopical evidence. (4) A small mammalian blood-stain cannot be sworn to be 'human' unless its origin is witnessed. It has been suggested that the analyst might aid by declaring the ratio of sodium to potassium salts. (5) Death, apart from severe mechanical injury, can seldom be certified until putrefaction has set in. In the case of a sudden death, it cannot be stated whether an unwitnessed bruise was inflicted immediately before or immediately after death. (6) The fact of a man having been drunk when he died can seldom be substantiated by a post-mortem examination of his body. (7) It cannot be proved whether an impulse which was acted upon was 'uncontrolled' or 'uncontrollable' (see p. 174). Lord Bowen once said, however: 'The state of a man's mind is as much a fact as the state of his digestion. It is true that it is very difficult to prove what the state of a man's mind at a particular time is, but if it can be ascertained it is as much a fact as anything else.'

The final variety of limitation is that imposed by the rules and policy of the law; it arises on account of the

essential strictness of the legal presumptions and of common law or statutory definitions, which become more rigid and precise with modern draughtsmanship and legislation. Thus indictable offences must be defined in exact terms, and the medical facts must, to be of any avail, be capable of being pigeon-holed—defending counsel will endeavour, as they did in the bad old days of special pleading, to fit the facts into a loophole if possible. Loose popular phraseology has led to occasional surprise in this connexion; thus in a moment of righteous anger it may be said of drunkenness: 'It 's a crime!' but, as a matter of fact, the law-books do not recognize it as such *per se*, although the drunken state may incidentally or consequentially lead to the commission of penal offences.

The English law places no restriction nor limitation upon testimony on the ground that such evidence was gained under the privileged circumstance of a medical adviser treating a patient—that is to say, there is no such privilege recognized *de jure*; but few judges would strive to extract such testimony from an unwilling witness. On the other hand, no limitation arises from the fear of defaming another person's character by evidence given in Court, for all statements made by a witness after being duly 'sworn' are privileged. There are, however, a few limitations imposed upon medical witnesses by rules of law. Thus, in England, the Court will not be influenced by purely medical

evidence which shows (1) That a woman or a man is past the age for procreation, and, in the case of the former, for bearing children (see p. 186). (2) That a child born nine months after lawful wedlock is illegitimate. (3) That, in the absence of eyewitnesses, a newly-born dead child was born alive (see p. 216). Such children are presumed to have been born dead until the contrary is proved. (4) That, in a common disaster, where the bodies have not been recovered and the deaths were not actually witnessed, a certain person must have died last. (5) That children under the age of seven years are capable of giving 'consent' or of committing an indictable offence. (6) That a boy under the age of fourteen years when a child was begotten, can have been its 'putative father'. The ground upon which these legal presumptions are based is to prevent vain, futile, and often irrelevant discussions upon subjects which are beyond the exact knowledge of mankind. In some continental systems of law, where codification is the rule, there are many more dogmatic presumptions, inserted often after medical assistance has been given to the codifiers. It is claimed that such presumptions prevent perjury and the waste of the Court's time. They are apt to work unjustly when enlarged knowledge and experience shows that they are not uniformly and universally correct.

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